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THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

POSSIBLE STRATEGIES FOR REFORM

A REPORT

PREPARED BY THE

CONGRESSIONAL RESEARCH SERVICE

FOR THE

COMMITTEE ON
POST OFFICE AND CIVIL SERVICE
U.S. HOUSE OF REPRESENTATIVES

MAY 24, 1989

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House of Representatives
Committee on Post Office
and Civil Service
Washington, DC 20515

TELEPHONE (202) 225-4054

June 15, 1988

Mr. Joseph E. Ross
Director
Congressional Research Service
Library of Congress
Room LM 203
Washington, D.C. 20540

Dear Mr. Ross:

The Committee on Post Office and Civil Service intends to conduct an extensive review of the Federal Employees Health Benefits Program (FEHBP).

The program in recent years has been plagued with substantial benefit reductions, skyrocketing premium increases and wildly fluctuating reserve levels. The Office of Personnel Management (OPM) has just released a consultant's report which is extremely critical of the program and outlines major problems that may require administrative and/or legislative changes.

Additionally, Congress has enacted legislation extending "catastrophic" health insurance coverage to medicare enrollees, many of whom are also covered by FEHBP. This will require the Committee to examine possible changes in FEHBP for medicare eligible annuitants.

All of these factors convince us that an in-depth, systematic analysis of the program is extremely important at this critical time. We are, therefore, asking the Congressional Research Service to assist us in carrying out this project. We would like you to assign the highest priority to this effort and to work closely with Committee staff on its scope and timetable.

Among the tasks we would expect you to perform for the Committee are:

1. Examine the current program, clarifying both its strengths and weaknesses.

2. Review the health insurance experience of both large private employers and state governments with comparable personnel needs.

3. Provide a definitive basis for analysis, including the development of such methodologies as are necessary to quantify relative cost and benefit comparisons of alternatives.

4. Develop a standardization of the terms and concepts pertinent to a legislative initiative, and a format for presentation of the relative advantages and disadvantages of particular health insurance options.

The Committee intends to ask OPM and the various organizations involved in FEHBP to cooperate with you in the development of any information you might need in the course of your work. We expect you will coordinate aspects of the overall project with the other legislative branch support agencies.

The Committee was extremely pleased with your assistance and support which proved so valuable when Congress enacted the FERS legislation.

We expect your study of FEHBP will contribute substantially to our work, and we appreciate the significant investment of your resources this will require. While we are aware of the other competing demands for your scarce resources, we would hope the project would be ready for Committee review by March 1, 1989.

With kind regards,

Sincerely,

William D Ford
WILLIAM D. FORD
Chairman
Committee on Post Office
and Civil Service

Gary L Ackerman
GARY ACKERMAN
Chairman
Subcommittee on
Compensation and
Employee Benefits

Congressional Research Service
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Washington, D.C. 20540

LETTER OF SUBMITTAL

May 18, 1989

Honorable William D. Ford
Chairman, Committee on Post Office and
Civil Service
and
Honorable Gary L. Ackerman
Chairman, Subcommittee on Compensation and
Employee Benefits
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairmen:

One year ago you requested the Congressional Research Service (CRS) to assist the Committee and its Subcommittee in ". . . an indepth, systematic analysis . . ." of the Federal Employees Health Benefits program (FEHBP). Your letter indicated the intent of the Committee to consider reform of the program, and asked CRS to provide a "definitive" framework for analyzing the issues certain to arise as the Committee began its work. This framework was to consist of standardized terms and concepts, information on the current program and practices of other large employers, and a methodology for analyzing and quantifying costs of the current program and the effects of alternatives.

In response to your request, the Service created the Federal Employees Health Benefits Team to conduct a study and prepare a report to the Committee. This report contains the findings of the study, and demonstrates a methodology that will be maintained for use by the Congress as it examines this important subject and considers any action it may wish to take.

Fourteen analysts and support staff from CRS participated on the FEHB Team. The project was managed by Janet Lundy, Michael O'Grady, and Dennis Snook. The FEHB team is:

- Velma Burke
- Brenda Freeman
- Thomas Gabe
- Geoffrey Kollman
- Carolyn Merck
- Bruce Mulock

- Susan Schillmoeller
- Ray Schmitt
- Ilene Shapiro
- James Storey
- Mallary Stouffer
- Dave DelQuadro, Congressional Budget Office

Edwin Hustead, Larry Bobbit, Michael Carter, and Mark Schafer of Hay/Huggins Company, Inc., provided actuarial and other technical assistance. Sheila Smythe, Chief Health Policy Advisor for the General Accounting Office, assisted the team in determining the scope of the study and provided helpful insights during its execution. Ken Cahill, Beth Fuchs, Janet Kline, and Jim Robinson of CRS provided substantive review.

We are pleased to transmit this report to you, and hope that it will serve your needs as you consider legislation affecting Federal employees' health insurance.

Sincerely,

Joseph E. Ross

Joseph Ross
Director

Enclosure

PREFACE

In June 1988, the Chairman of the House Committee on Post Office and Civil Service, the Honorable William D. Ford of Michigan, and the Chairman of the Subcommittee on Compensation and Employee Benefits, the Honorable Gary L. Ackerman asked the Congressional Research Service (CRS) to assist the committee in ". . . an in-depth, systematic analysis . . ." of the Federal Employees Health Benefits program (FEHBP). Citing the program's ". . . substantial benefit reductions, skyrocketing premium increases and wildly fluctuating reserve levels . . ." and the passage of the catastrophic health insurance provisions for Medicare enrollees, Chairman Ford and Chairman Ackerman indicated the intent of the committee to consider the need for reform of FEHBP. The CRS project was charged with four primary tasks:

- An examination of the current program, ". . . clarifying its strengths and weaknesses."
- A comparison of FEHBP to the practices of ". . . large private employers and State governments . . . ."
- Development of a "definitive" framework for analyzing the various plans and practices, which would be based on methodologies that could quantify cost and benefit alternatives.
- Standardization of the ". . . terms and concepts pertinent to a legislative initiative . . ." and development of presentation techniques so that comparisons could be understood.

ORGANIZATION OF THE RESPONSE

In response to the committee's request, CRS agreed to conduct a study, produce a report, and provide an analytic capability that would assist the committee in understanding FEHBP's problems and possible solutions.

Drawing upon expertise in various disciplines, analysts from several divisions within CRS formed the Federal Employees Health Benefits Team to conduct a thorough examination of FEHBP. The FEHB Team was supported in this endeavor by staff from the Congressional Budget Office (CBO) and the General Accounting Office (GAO), with actuarial assistance from Hay/Huggins Company, Inc. The Office of Personnel Management (OPM) cooperated extensively in the development of study objectives and provided needed data and technical assistance as requested. Employee organizations and representatives of plans participating in FEHBP also provided information for the study.

The FEHB Team responded to the committee's request by undertaking:

- A study of the current FEHBP structure, its plans and participants, and problems arising from its operation;

- A review of approaches taken by other large employers providing health benefits for their employees;

- Development of a framework for understanding and analyzing the issues in the design of a health insurance plan and a methodology for quantifying pertinent aspects of alternative designs;

- Creation of a baseline, so that costs and benefits of alternatives could be compared relative to consistent standards. This baseline consists of "polar" reference points for both costs and benefits. One pole represents current costs and benefits for the Federal Government and for program participants. The other pole reflects costs and benefits of a plan "typical" of private sector plans as if that plan covered a population representative of the Federal workforce; and

- Preparation of a report to the committee that will provide explanations and analyses of the issues in FEHBP reform and will demonstrate an analytic capability available to Congress as alternatives are considered.

STRUCTURE OF THE REPORT

The report is divided into two parts and several appendices. Part I contains three chapters:

- An *Overview* that explains the general issues pertaining to FEHBP and summarizes the findings of the study;

- A *Background* that provides information on FEHBP, together with explanations of basic concepts and terms relevant to an understanding of health insurance; and

- A *Strategies for Reform* chapter, which demonstrates the analytic methodology in the context of issues arising from FEHBP reform.

The strategies in chapter 3 are illustrations and are not intended as proposals, nor have they been constructed with specific proposals in mind. The possible variations in FEHBP designs, together with possible variations in the plans that might occur within FEHBP are numerous. These illustrations are a way of presenting alternatives so that the analysis of variations does not become unmanageable.

The three illustrative strategies represent an array of alternatives ranging between the existing FEHBP and practices of other large employers. Each strategy has six components, and each component has several variations which, where appropriate, are compared to each other.

The second part of the report contains six chapters that develop the analyses of important FEHBP issues in greater detail. These six chapters are:

- *Health Plan Design*, which examines the design of employer-sponsored health plans including FEHBP;

- *Comparability with Private Sector Practice,* which compares FEHBP to practices of other large employers, and provides examples of innovative approaches to employee health insurance;

- *The Issue of Choice*, and its impact on FEHBP and possible reform alternatives;

- *Treatment of Annuitants*, which examines issues in the treatment of annuitants within FEHBP;

- *Administration of Health Insurance Programs*, which discusses the issues in administering the present program and alternatives for change; and

- *Costs and Financing*, which analyzes the costs of the current program and how those costs are financed.

The *Appendices* contain more detailed background on FEHBP and its legislative history, together with an explanation of the methodology used in the report.

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THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND POSSIBLE STRATEGIES FOR REFORM

SUMMARY

The Federal Employees Health Benefits program (FEHBP) will spend $8.2 billion in FY 1989 Federal outlays to cover 9 million employees, annuitants, and dependents. This report analyzes FEHBP issues in four major areas: (1) enrollee choice among health plans; (2) treatment of annuitants; (3) rising costs; and (4) differences between FEHBP and other employers' plans.

Enrollees choose among 21 to 37 plan options depending on location. These choices result not from a systematic design but from a mix of statutes, regulations, agency/plan negotiations, and marketing decisions of insurers and employee groups. FEHBP gives enrollees a chance to maximize benefits, but the design poses problems: (1) risk segmentation has led to a concentration of high-risk enrollees in a few plans; (2) an enrollee's premiums are based on his/her plan's experience, not that of FEHBP as a whole, yielding premium costs far in excess of benefit values in some plans; and (3) a lack of design standards and limited information on benefit rules put less informed enrollees at risk of making choices that may cause high out-of-pocket spending.

The 1.5 million annuitant enrollees comprise an unusually large share of participants compared to private plans. While annuitants have above-average health costs, half are Medicare eligibles who, because they cost FEHBP less than other enrollees, lower the premiums other participants must pay. The disparity in FEHBP premium payments versus benefits for the different annuitant groups and concern about the new Medicare catastrophic premiums have led to consideration of separate treatment of annuitants within FEHBP or creation of a Medicare supplemental plan for Medicare eligibles.

Program costs have risen by 12 percent a year since 1980, which is in line with health care cost inflation. There is concern that risk segmentation may drive up costs, but no evidence points to it as a major factor in total FEHBP costs. However, risk segmentation has raised the Federal share of costs since the cost-sharing formula gives added weight to costs of plans with risk segmentation problems. FEHBP has not adopted program-wide the cost control measures used in the private sector, and market share competition tends to offset carriers' incentives to implement strict cost controls.

Health plans of nonfederal employers differ sharply from FEHBP. Fee-for-service options are few in number but incorporate choices designed to appeal to a broad spectrum of enrollees. Preferred provider organizations are widely used. Most large employers self insure their plans and manage them directly or under contract. Employee Self Only coverage is often provided at little or no cost; enrollee charges for Family coverage are often structured to reflect family size and composition. Health plans are being offered within cafeteria plans by a growing number of employers. A comparison of Federal benefits with those in the private sector shows that health benefits for a typical employee are worth $1,100 more in the private sector.

The Federal Employees Health Benefits Program and Possible Strategies for Reform

Prepared at the Request of the
House Committee on Post Office and Civil Service
Subcommittee on Compensation and Employee Benefits

The Federal Employees Health Benefits Team

May 18, 1989

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THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND POSSIBLE STRATEGIES FOR REFORM

CHAPTER 1. OVERVIEW

I. INTRODUCTION

As the Federal Employees Health Benefits program (FEHBP) nears the end of its third decade of operation, it is undergoing scrutiny because many believe that the program no longer effectively serves the interests of the Federal Government, or of its current and former employees and their dependents. The annual "open season," during which participants elect a plan for the following year, causes considerable anxiety for some people who sense the need to make an important decision about which they understand little. Many retirees believe that they are unfairly treated under the program, especially in light of recent changes to Medicare. Others affected by the program are concerned that premium increases are larger than necessary. Finally, some question whether the program's principal distinguishing characteristic, choice among many plans, has undermined the effectiveness of the program itself.

Findings of the Study

The following are the findings of the study:

- Choice among many plans in FEHBP gives workers and retirees an opportunity to elect plans that most closely match their expected need for medical services. Enrollees can also elect plans that require lower premiums.

- These selections are generally in the interest of the individual enrollee, but can be "adverse" to the collective interests of an insured group. To guard against adverse selection, many plans design benefits to appeal to lower-risk, and discourage higher-risk enrollees.

- Choice among plans, in conjunction with the method by which the Federal share of premiums is calculated, has resulted in concentrations in some plans of persons with similar risks. This phenomenon is called "risk segmentation."

- Risk segmentation has led to substantially different premiums for the benefits of some plans, relative to the premiums that would occur if the plans covered the entire FEHBP population. For instance, a measure of standard benefit value shows a range of 41 percent in the value of benefits in FEHBP plans, while the range in their total premiums is 246 percent.

- This disparity in benefit values allows some enrollees to gain advantages, the sum of which largely match disadvantages borne by others. Because the Government generally contributes a fixed amount toward each plan, premium differences from plan to plan due to risk segmentation affect costs primarily borne by enrollees.

- The evolution of benefit packages makes informed choice difficult. About 16 percent of enrollees are in plans that have "scheduled allowances" for provider payments that can make financial exposure difficult to recognize. About 34 percent are in plans in which total premiums exceed the standard value of benefits.

- The presence of choice among plans does not have a significant effect on total program costs. However, the formula for calculating the Federal share of FEHBP premiums interacts with choice in a way that causes the Government share to rise.

- Federal payments for health insurance for the average Federal employee are approximately $1,100 per year less than employer payments for health insurance of a typical private sector counterpart.

- In FEHBP, the average enrollee pays about 29 percent of the average cost of benefits. This average enrollee share of benefit costs represents about 34 percent of costs of active workers, about 38 percent of costs for annuitants covered by Medicare, and about 18 percent of costs of annuitants in FEHBP only.

- If the Government paid the same share of benefits for annuitants covered by Medicare as a group as it now pays on average for the program as a whole (71 percent), then their average premiums could be significantly lower.

- Many annuitants in FEHBP and also covered by Medicare, waste thousands of dollars of their own money by being in plans that require high premiums for benefits they cannot use.

- Nevertheless, on average, Federal annuitants covered by both Medicare and FEHBP have benefit payments from FEHBP that exceed their premium payments.

- Average increases in total program costs over the last 10 years are not unusual when compared to the experience of private sector health insurance plans.

- Money could be saved by adopting cost controls throughout the program and by eliminating unnecessary expenses not related to claims payments.

- More effective administration of the program is possible, and incorporating private sector innovations in health plan management could improve its operations.

- Major structural change to the program could solve perceived problems, but would not save money unless it was coupled with benefit reductions, more cost shifting to participants, or direct controls on providers.

This report examines FEHBP, compares it to the plans of other large employers, establishes a framework through which issues in the program can be understood, and displays methods by which the performance of the program and potential alternatives can be measured. The report begins with an overview of the program and the issues arising from consideration of reform.

A. History of FEHBP

Thirty years ago, Congress created a comprehensive health insurance program for Federal employees. FEHBP insures participating employees and retirees against financial hardship arising from costs of medical services. When enrollees or their covered dependents use medical services, part or all of the cost of those services can be paid by the program through one of its subsidiary plans. The cost of the program is shared between participants and the Government.

Before enactment of the program, Federal employees were generally responsible for securing their own health insurance. While some agencies offered group health insurance plans, there were no Federal contributions to those plans. A few employee organizations offered group health insurance to their members. Other employees purchased their own health insurance or were covered through the dependent provisions of their spouse's health insurance. Most had no health insurance.

After enactment of the original legislation in 1959, Blue Cross/Blue Shield (BC/BS) and the Aetna Life Insurance Company created Government-wide health insurance plans, each with two levels of benefits (high and low options). Employee organizations were authorized to establish plans for their members, and 13 organizations offered such plans. Also participating were 21 health maintenance organizations (HMOs), described in the law as "comprehensive medical plans."

B. Description of the Current Program

By 1989, the program has grown to include 30 different options that directly insure participants for covered services, and nearly 440 HMOs. Employee organizations sponsor 26 of the fee-for-service (FFS)[1] options. Each employee and retiree actually chooses from no more than 37 options, and no less than 21 options, the difference primarily determined by the number of HMOs available in the individual's local area.

There are 2.5 million employees, 1.5 million annuitants, and 5 million dependents in the program. About 16 percent of eligible employees elect not employer subsidy to FEHBP. Most of these people are covered through some other health insurance, often provided by the employer of a spouse. Certain temporary employees, and retirees not participating in the program during the 5 years before retirement are ineligible. About 450,000 employees, and about 500,000 annuitants do not participate in the program.

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[1] In FEHBP, service or indemnity plans are both officially referred to as "fee-for-service." Elsewhere in the health insurance industry that term is often used to refer to a specific structure for paying providers, rather than to an insurance plan itself.

The program is administered by the Office of Personnel Management (OPM). Although OPM has some influence over the benefits in individual plans, each plan is relatively free to design a package of benefits to appeal to enrollees during the annual "open season." The plans estimate premiums based on their anticipated costs for the upcoming year. In 1989, the total cost of FEHBP will reach $11.6 billion, of which the Federal Government (including the U.S. Postal Service (USPS)) share will be about $8.2 billion, or about 71 percent of the program's total cost. Enrollees will pay a total of about $3.4 billion in their share of plan premiums.

The Government share of each plan's premium is the dollar amount equal to a percentage (60 percent) of the average cost of six plans (the Big Six), which are specified in law as: (1) the higher of two options offered by BC/BS and Aetna (High Options), and (2) the two employee organization plans and two HMOs with the largest enrollments. In 1989, the Federal share of total premiums averages 71 percent, because of the high premiums for the two High Option plans in category (1). The Federal share cannot exceed 75 percent of the premium for any plan. An exception to this rule applies to postal workers, whose collective bargaining agreements with the USPS provide an employer share for postal workers of 75 percent of the Big Six, up to a maximum of 93.75 percent for any plan. For 1989, the average USPS contribution is 87 percent of the total average premium. In each plan, enrollees are responsible for the share of the premium not paid by the Government or USPS contribution.

II. PROGRAM ISSUES

Most major issues arise from three distinguishing characteristics of the program.

The existence of choice. The program gives participants a choice among a wide variety of individual plans that are relatively free to compete for participants by offering benefits at competitive premiums. This array of choices has led to a very uneven distribution of benefits and burdens among program participants. Some enrollees are uncertain or confused about the comparative value of different coverage, and some choose plans with difficult to recognize financial exposure. This situation has raised three policy questions:

- Does choice serve a useful purpose in the program?
- Should FEHBP strive for more uniformity in benefits and a more equal distribution of participants' costs?

- Is it the Federal employer's responsibility to protect its employees and retirees from unwise choices?

The treatment of annuitants. Annuitants can participate in the program on the same basis as employees. In addition, many annuitants are also covered by Medicare. In the past, some annuitants have seen this overlap in coverage as a reduction in the value of their retirement compensation package. With the enactment of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), many Federal annuitants believe that they have been unfairly burdened with a tax to support additional coverage that they neither want nor need.

The presence of annuitants in the program has had significant effects on certain plans. Because they are generally an older group, annuitants use more services. A concentration of annuitants in a plan will skew that plan's costs relative to the "value" of the benefits, when those benefits are measured against a common program standard. However, when this population reaches age 65, Medicare becomes the primary payer, thereby moderating the cost effects for annuitants under 65.

The treatment of annuitants in FEHBP raises two policy questions:

- Are Federal annuitants treated fairly with respect to health insurance?

- What would be the effect on FEHBP and its participants if annuitants were treated separately?

The issue of costs. Compared to the health insurance provided by other large employers, FEHBP places a heavy burden on employees' pocketbooks. Yet, in an era of Federal budget concerns, pressure exists to reduce the Government costs for FEHBP, especially in light of the rapid growth in costs of medical services. Key issues are:

- Are the costs of FEHBP unreasonable to the Federal Government and program participants?

- How might program reforms affect FEHBP costs?

In the following sections, these issues are introduced. Further discussion may be found in subsequent chapters of the report.

A. Choice

Group insurance implies that choice does not occur, it being a principle of group insurance that the burdens are shared by all regardless of the costs incurred by each. Because FEHBP permits enrollees to choose among different plans, the total participant population is not insured as a single group, but insurance is deployed through specific plans, which insure that plan population separately.

What do participants gain from this choice in plans?

Defenders suggest that this broad choice gives participants three principal advantages:

- Competition among plans results in a wide variety of benefit packages.
- Participants are able to select the plan best suited to their expected needs, thereby gaining the most from their premiums.
- Competition among plans leads to the most efficient provision of services to participants and lowers program costs.

Federal enrollees and retirees can choose between Self or Family coverage, between FFS plans and HMOs, among numerous examples of each, and between two "options" (High or Standard) within some plans. No other employees and retirees have the number of choices available to FEHBP participants. This wide variety of choice was apparently not planned at the time the program was created, but it evolved in the absence of any direct effort to prevent it. The program is a special marketplace, the governing forces of which are neither assertive Federal authority nor free market competition, but elements of both.

Federal employees bear a considerable portion of the premiums for coverage, and can claim that this payment warrants a choice among benefit packages. An employer granting choice in health insurance options appears to acknowledge that individual enrollee circumstances differ sufficiently, so that enrollees should have the right to consider their specific circumstances when selecting coverage. For instance, many individuals are eligible for coverage elsewhere as a spouse, and may choose a plan that supplements that additional coverage, at a premium less than more comprehensive coverage would require.

Choice in the private sector. Choice among plans under employer-based programs in the private sector is much more limited than under FEHBP. In the private sector, premiums for employees' health insurance are usually paid by the employer, who also usually pays most of the premiums for dependent coverage. An increasing number of employers insure benefits themselves, contracting for claims processing and upward limits on losses associated with specific cases ("stop-loss"). Choice among FFS plans is not offered because the employer establishes coverage agreements with a plan that sets premiums for the group as a whole. Insurers compete for employee groups, not individuals. Because employees in private firms generally do not bear the premium costs directly, they do not have as strong a claim that they should determine the plan in which they participate.

Private sector employees can often choose to participate in an HMO, but this choice yields broader coverage in return for the restrictions on the choice of provider that HMOs require. Some employers offer incentives for employees to enter HMOs because these prepaid arrangements are thought more effective in restraining costs while providing comprehensive coverage.

Choice among elements of compensation. In recent years, many private sector employers have offered fringe benefit arrangements whereby employees are allowed to select from among different health insurance benefit packages. Employees choosing plans of lesser value are able to devote the cost difference to other fringe benefits, or to wages. These flexible benefit plans are explicit recognition that the costs of all fringe benefits are a part of total compensation.

Employees sometimes advocate these flexible benefit approaches because they allow more control over the structure of their compensation. Employers recognize that these plans provide them an opportunity to fix compensation costs directly, rather than have a substantial portion of those costs uncontrolled. Health insurance is a large item in an employer's compensation requirements. Costs of health insurance are tied to the rate of increase in health care costs, which is increasing at a rate faster than the rate of wages. These flexible plans are sometimes seen as ways to reduce the growth in the value of the total compensation package.

Why didn't competition work to create an "efficient" market in FEHBP?

Some observers compare FEHBP to a "marketplace" in which health insurance can be purchased by individuals from among competing plans. Yet, several conditions mitigate this marketplace analogy:

- Entry into the market is restricted.

In an ideal competitive market, suppliers can enter without restriction, offering products that could substitute for ones already available. In FEHBP, new FFS plans can be approved only through legislation. HMOs can enter by meeting OPM's regulatory standards, and the increase in the number of such plans is a challenge to the financial stability of the FFS plans. Because HMOs are sometimes more appealing to younger enrollees, they cause an upward pressure on the costs of competing FFS plans.

- Profits are limited and plans are insulated from the effects of their mistakes.

FFS plans are limited in the profits and fees they are permitted to earn. When plans underestimate the level of premiums for the benefit package they provide to the enrollees, they set premiums sufficient to recover that loss. When they overestimate, they reduce premiums to return the gains. Thus, two conditions of an ideal competitive market are not present: There is neither opportunity for significant gain nor substantial loss.

- Differences among plans are difficult to ascertain.

Plans are similar in many aspects. All cover the same basic services, and most use common terminology to describe their coverage. Yet, important differences exist in the interaction of various provisions, so that actual benefit expenses may vary from plan-to-plan for the same services. Adequate information about similarities and differences is not readily available or easily understood, making "comparison shopping" difficult.

- In the face of "adverse selection," even if the other conditions for a competitive market hold, insurers will have to offer plan choices that will not be "efficient" for all consumers.

When insurers do not have adequate information about the health risks of their potential subscribers, they face a situation in which those subscribers may know enough about their own conditions to select a health insurance plan based upon its expected payments. Private sector insurers respond to this potential for "adverse selection," segmenting their risks by offering comprehensive coverage at appropriate prices to attract high-risk customers, and less than comprehensive coverage at a lower price to attract healthier individuals. This results in less than desired coverage for low-risk individuals, and higher costs for high-risk individuals than would be the case if premiums for more comprehensive coverage could be offered without regard to adverse selection.

Because of the way FEHBP now operates, its plans have little incentive to be efficient, because their success depends not on their effectiveness as group medical insurance, but on attaining an adequate number of low-risk users. Indeed, a plan has virtually no incentive to distinguish its product in a way that would appeal to high-risk users.

Given these limitations on competition within FEHBP, it seems likely that the full advantages of open competition are not being realized. The most important manifestations of these limitations are: (1) a range of choices that, while significant, falls short of actual benefit variations available in the centrally designed programs of many other large employers; (2) product pricing that reflects the health status of a plan's customers, often more than the basic value of the plan's benefits; (3) a set of outcomes that favors the most knowledgeable enrollees; and (4) confusion for customers who want to price-shop but have difficulty in determining the real value differences among the plans.

In FEHBP, competition for market share is more important than competition for profits at the risk of loss.

The most important competition in FEHBP appears to be for "market share." Because there is no opportunity for entrepreneurial gains or losses, plans raise or lower their financial position on the basis of enrollments. Higher enrollments mean more overhead expenses for claims processing, plan management, and other expenses. HMOs, particularly those that own and operate their own facilities, are especially interested in the impact of enrollment on "economies of scale." Declines in enrollment mean less revenues, which in turn can mean layoffs in plan staff, or other difficulties in meeting regular financial obligations.

Employee organizations generally view their health plans with pride, and large enrollments are important for prestige. Several organization plans have become established and enduring financial operations in their own right, with the usual organizational imperatives to survive at the level of operations attained. Furthermore, employee organizations that charge an annual fee for nonmembers to enroll in the health plan have an obvious incentive to increase enrollments, and understandable concern about their decline.

For HMOs, the changes in enrollments have a potential impact on overhead expenses, but there is an additional financial aspect to their rating structures. HMOs compete with other plans, both inside and outside of FEHBP in specific localities. HMOs are viable if the contracts they have with providers, permit the provision of all covered services to a specific group of employees insured for a specific per capita fee. HMOs are at risk for greater than anticipated costs of utilization for groups of employees covered as a result of contracts with employers in their service area.

What is "risk segmentation," and what are its effects on FEHBP plans?

Choice in FEHBP has led to "risk segmentation." Risk segmentation results when many individuals with similar expected demands for medical services congregate in the same plans.

For example, many participants have remained in certain plans from the beginning of the program. These people, now often retired, are older and more likely to have higher health care expenses. Because plan premiums are determined by estimating the claims likely to be paid for the group enrolled in the plan, this congregation of risks causes those plan premiums to rise. As premiums rise, participants who do not expect to experience high claims migrate to plans that have lower premiums, causing the original plan to have an even higher average utilization. This escalating incentive to escape a plan that has a rising average utilization is called a "risk spiral."

Several effects follow from this segmentation.

- The premiums in many plans are affected more by enrollee characteristics, especially age, than by the value of plan benefits.

The FEHB Team developed a methodology that allows the value of plan benefits to be compared as if they were offered to a population representative of the entire FEHBP population, referred to throughout this report as the standard Federal population (SFP). Some plans have benefit packages far less valuable than the premiums charged, while others are an especially good bargain when measured against this "actuarial" standard. The team found that the actuarial value of the nine plans with the largest enrollments vary by no more than 35 percent, but the total premium (Federal plus enrollee share) for the highest cost plan is 246 percent greater than that of the lowest cost plan.

This effect of population variance on premiums has caused some plans to have tremendous swings in the value of benefits relative to premiums, with large shifts in enrollment as workers and retirees recognize that disparity. People moving from one plan to another experience uncertainties in their coverage. Others manage to avoid premiums they would have had to pay if all FEHBP enrollment were under any one plan.

- Plans have an incentive to limit benefits attractive to older participants, because they are required to raise premiums to levels sufficient to insure the covered population, plus recover past losses.

The most important factor in determining a plan's financial stability is the population it attracts. Younger, healthier participants are more "desirable" from a plan's standpoint. Because plans set premiums to recover past losses as well as insure the expected population, increasing average age causes increases in premiums for plans that have acquired an expensive mix of risks.

Thus, plans are discouraged from offering some benefits, and have the incentive to offer others. Some plans have adopted aggressive marketing tactics that seem intended to appeal to younger people. Plans also have little incentive to incorporate cost control mechanisms if plan administrators perceive them to result in participant dissatisfaction and migration to another plan.

- Annual open seasons have become complex and confusing, and adequately informed choice is generally not attained. Some participants select plans that have insurance "gaps."

Although most FEHBP plans are similar in important ways, many differences do exist between them, and some can be very important as well as poorly understood. The evolution of benefit packages has made them quite complex, and it is difficult for many, perhaps most Federal workers and retirees to make an informed, rational choice among plans. Agency personnel offices vary in the degree to which they are able to assist in the choice, and OPM cannot eliminate confusion by developing information adequate to the needs of all enrollees. Many have chosen unwisely to stay in plans in which the benefit package is far more costly than a similar package in another plan. Others are in plans that could leave them with thousands of dollars in unexpected medical bills, after all plan insurance has been provided.

B. Annuitants

As older people, annuitants on average use more medical services than active workers. Thus, FEHBP is an important element in the retirement rights earned through Federal employment. Most annuitants age 65 and over are also entitled to Medicare, which has prompted demands that benefits of the two programs be more coordinated. Recognition of this overlapping coverage raises questions about the equitable treatment of the annuitant population.

How are annuitants treated under FEHBP and Medicare?

About 1.5 million annuitants are enrolled in FEHBP. Eligible annuitants have the same rights as workers (open seasons, dependent coverage, choice in plans, premiums), and each plan places retirees in the same risk pool with workers.

Upon reaching age 65, most Federal annuitants become eligible for Medicare Hospital Insurance (HI, Part A). At age 65, retirees are also eligible to enroll in Part B (as are all U.S. residents age 65 or older), which pays some or all of physicians' or other medical services. Beginning in 1989, persons eligible for Medicare also receive catastrophic coverage protection, financed from an increase in the Part B premium and a new supplemental premium (surtax) based on income tax liability.

Except for differences in the calculation of the supplemental premiums for catastrophic protection, Medicare treats FEHBP annuitants the same as other eligible persons. Because the new catastrophic coverage is financed primarily by the income tax surtax, the different tax treatment of social security old age benefits relative to public employee retirement benefits created pressure to exempt a portion of Federal benefits from the calculation of the liability for the catastrophic premium.

Because most medical services are covered by both Medicare and FEHBP, the programs coordinate their benefit payments to eliminate double payments. Medicare is the "primary payer" for annuitants with dual coverage, and thus pays for most hospital and/or physician services. Because OPM requires FEHBP plans to waive coinsurance and deductibles for annuitants covered by both programs, those retirees have virtually 100 percent coverage for hospital and doctor bills.

The new catastrophic coverage will fill gaps for annuitants in some FEHBP plans, but it will have little effect on total coverage for most retirees. Medicare will pay for more medical expenses than it did before, in effect shifting costs from one Federal program to another. The new law included a provision that reduces the annuitant's share of FEHBP premiums to reflect the amount FEHBP would save. In 1989, FEHBP premiums are reduced by $3.10 per month for annuitants also eligible for Medicare.

What results from annuitant participation in FEHBP?

There are two important findings that illustrate how annuitants and FEHBP plans interact:

- Although annuitants with Medicare reduce the costs of the plans in which they enroll, this effect is more than offset by the high costs associated with annuitants without Medicare.

- Many annuitants entitled to Medicare do not choose lower-cost FEHBP plans, even though it is clearly to their advantage to do so.

As a group, because annuitants are the most expensive enrollees to insure for medical services, they tend to increase the cost of health insurance plans. Probably because they have been in the program the longest, and have remained with certain plans with which they are most familiar, they have concentrated in certain plans. The costs of these plans have risen, and as they have, younger persons whose "loyalty" to a specific plan is less firm have left in search of better benefit value in another plan. This migration of younger workers increases the cost of their former plans even more.

Many annuitants with Medicare waste thousands of dollars every year in unnecessary premiums by remaining in these high-cost plans that provide a high degree of duplicative coverage. In addition, because many younger enrollees have left these options, their costs have increased because of the rising level of "risks" remaining. Thus, the effect of a concentration of annuitants in any plan is to initiate a contest in which those with the greatest understanding of the dynamic at work will be the first to go. Those that remain, often the oldest, or sickest, or least familiar with the operations of group insurance, are the ones who pay the most for FEHBP relative to benefits received.

Are annuitants treated fairly under FEHBP?

Annuitants not covered by Medicare clearly have a benefit in retirement of considerable value. Because they are more costly to insure than other groups, their premiums are lower under the current system than they would be if all annuitants were in a separate risk pool and were rated separately.

For annuitants covered by Medicare, the issue is substantially different. As costs of FEHBP coverage have risen, annuitants have complained that they are disadvantaged as a result of overlapping coverage and additive premiums. The advent of catastrophic coverage, with its accompanying taxes, has caused Federal annuitants to protest this dual coverage with vigor. Simply put, these Federal retirees assert that they have acquired no significant new benefits as a result of the passage of catastrophic coverage and that they are being assessed a burdensome tax, even if they reject Medicare coverage.

The FEHB Team has determined that the following circumstances govern a conclusion about the fairness with which annuitants covered by Medicare are treated under FEHBP.

- On the whole, Federal annuitants covered by Medicare receive benefits paid by FEHBP that exceed the value of the average premium paid by that group.

Medicare pays most of the costs for annuitants with double coverage, which clearly lowers the value to them of coverage under FEHBP. However, because annuitants generally have higher medical expenses, and FEHBP coinsurance and deductibles are waived, FEHBP also pays benefits for these retirees that it does not pay for other program participants. Although the value of the Federal share of the contribution differs from plan to plan, that share does help support the cost of annuitants covered by Medicare.

After balancing the respective benefits and costs of combined coverage, the average FEHBP benefits received by annuitants also covered by Medicare exceeds the average premium paid by those participants. "Medigap" policies purchased individually from private sector vendors would not generally be a good purchase for most annuitants eligible for both FEHBP and Medicare, because the Federal contribution to help pay the cost of benefits would not be present. Thus, annuitants covered by Medicare, as a group can be said to get their "moneysworth" from participating in FEHBP.

- By and large, the private sector provides less health insurance coverage for retirees but usually at nominal cost to the retiree.

In the private sector, about 24 percent of employers do not provide medical coverage to retirees. Of those that do, 90 percent extend coverage past age 65. About half the time, the coverage was provided at no cost to the retiree; only 15 percent had to pay the full cost of coverage. Private sector annuitants whose employers provide them with broad coverage after age 65, also are critical of the new Medicare catastrophic coverage, asserting that the additional catastrophic tax gives them little or no additional coverage.

- Federal annuitants covered by FEHBP and Medicare, although treated differently, are treated with "relative fairness" compared to their private sector counterparts, under the surtax financing catastrophic coverage.

Federal retirees are allowed an adjustment in determining their relative placement within the distribution of the burden for financing the additional coverage. The catastrophic surtax is computed on the basis of income tax liability, and because social security old age benefits are at an advantage relative to some Federal retirement benefits in determining income tax liability, the law establishing the catastrophic protection contained an exemption for a portion of Civil Service Retirement System (CSRS) annuities before the surtax liability is computed. While further study could show that the amount of this exemption might need adjustment for certain categories of Federal annuitants, that does not suggest that Federal retirees covered for health insurance by both FEHBP and Medicare are treated unfairly by the application of the surtax itself.

The catastrophic legislation is predicated on the assumption that many individuals were without such coverage, and indeed data show that many elderly were exposed to the circumstances covered by the additional insurance. The supplemental premium tax to finance the coverage is intended to reflect the experience of Medicare beneficiaries, with the burden for the financing distributed progressively among the members of the entire Medicare population.

Some have suggested that the coverage should be financed on a broader population than those eligible for its protection. This claim rests on an assumption that catastrophic coverage is more of a social insurance benefit that should be financed with transfers from the general population.

- Federal annuitants covered by both FEHBP and Medicare pay a higher percentage of their benefit costs than do other participants in FEHBP.

Because Medicare pays most of the medical bills of retirees covered by both programs, such annuitants cost FEHBP less than other groups within the program. Nevertheless, those FEHBP annuitants pay premiums that are identical to those paid by other enrollees. Thus, these annuitants assert that they are unfairly subsidizing the premiums of other FEHBP participants.

In 1989, the average enrollee share of premiums is 29 percent. This average share represents 18 percent of the cost of benefits for annuitants not covered by Medicare, and rises to 38 percent for annuitants covered by Medicare. The average share for workers is 34 percent.

Thus, while these annuitants covered by Medicare, as a group, do receive benefits greater than the average value of their own premiums because of the Federal payments, they receive a much smaller than average share of the Federal Government payment to the program. If a systemwide medigap plan were created, an issue would arise as to the proper share of the plan's premiums to be borne by the Federal Government and enrolled retirees. If the average Federal share of costs for this group were increased to the same percentage as the current system average Federal payment, then their premiums could be, on average, 24 percent smaller than the system average.

There is no objective basis for determining the appropriate share of FEHBP premiums that should be paid by the Federal Government to Federal annuitants covered by both Medicare and FEHBP. The value of the Federal share to FEHBP is more heavily weighted toward younger retirees than active workers or retirees covered by both programs. Annuitants with Medicare who argue that they unfairly subsidize others, make an implicit claim that the Federal payment for their premiums should have the same average value as that paid for all others in FEHBP. Yet, the value of the Federal subsidy varies from plan to plan for all participants, as does the value of the subsidy each individual receives from the Government and/or exchanges with all other participants.

The right to participate in the program is earned by a Federal career, and employers have an obligation to determine the proper balance between adequate protection and equitable treatment for the workers it employs, but such a balance most clearly applies to the treatment of workers in service contemporary to each other. The proper share of total compensation distributed between workers and retirees is difficult to establish, given that the relative values of each can change significantly during the course of a person's career and subsequent retirement. In FEHBP, generational transfers of program subsidies are passing phases rather than distinctions within an objective of equitable treatment. A high probability exists that a retiree will pass through all phases during a lifetime.

Could premiums for the annuitant population be determined separately from others in FEHBP?

It is sometimes suggested that Federal annuitants should be placed in a separate coverage group with separate premium ratings. Separating the categories of risk, and changing annuitants' different premiums would diminish the extent to which concentrations of retirees in certain plans drives up their costs and makes them less desirable for younger workers. On the other hand, the premium for the annuitant group would rise, and the claim that annuitants covered by Medicare are unfairly subsidizing others would be even stronger.

Sometimes when private sector employers provide health insurance to their retirees, they treat them as a separate risk group with corresponding separate premium rates. However, this treatment of retirees is not particularly relevant to FEHBP for two reasons.

First, on average, private sector plan sponsors are not faced with a large number of retirees so young that they are not eligible for Medicare for many years, as is common to FEHBP, even though the average age of retirement is fairly close in both private and Federal employment. Private sector retirees cluster their entry into retirement around the age of 62, when the old age portion of social security benefits first become payable. While average Federal retirement is also around age 62, Federal retirees often retire as early as age 55. Thus, compared to FEHBP, the private sector employer-based health insurance plan bears the full cost of retiree health insurance for only a few years for most enrollees, before Medicare begins to pay most retiree health care costs.

Second, in the private sector, the premium responsibility for health insurance is borne almost exclusively by the employer, with the retiree responsible for a portion of dependent coverage. Thus, a separate risk group makes little difference to the total obligation of the employer for health insurance, provided the employer is committed to providing retiree coverage. However, the separate risk group has made the high cost of retiree health insurance evident and is making such coverage an issue in private sector employee benefit relations. This issue can be expected to intensify, as pressure mounts for firms to account for these obligations as liabilities against the firms's assets.

Could annuitants over age 65 ineligible for Medicare be brought into that program?

If the Federal Government were to purchase Medicare for annuitants otherwise ineligible for its benefits, FEHBP costs would be lower, as Medicare would become the primary payer for benefits now paid from FEHBP. These annuitants would receive greater coverage than they do now, as their FEHBP deductibles and coinsurance would be waived. To the extent all annuitants over age 65 would be treated uniformly, there would be less confusion by annuitants in choosing health plans, and administration would be simplified.

However, cost savings to FEHBP would be mitigated because most nonmedicare-covered annuitants are too young to be enrolled in Medicare. Moreover, these savings may be completely offset by the cost of purchasing the Medicare coverage, and by the resulting rise in Medicare outlays. Savings realized may be only to the extent Medicare cost containment efforts prove more effective than those in FEHBP.

Could a separate option for annuitants covered by Medicare be created?

Separate options for annuitants covered by Medicare could be created that would reflect that group's experience and whose benefits would be designed to supplement rather than overlap Medicare's coverage. New options that take into consideration the benefits paid by Medicare for these annuitants might be better designed than any plan now available to them because it would be intended for a defined group. Although the structure through which coverage is provided structure would be more clearly identifiable than the current overlapping FEHBP approach of FEHBP and Medicare, there is no necessity for the total cost of benefits from the combination of Medicare and a special supplement for Federal annuitants to differ from what is now received.

If the total value of benefits from a new program were to include the total value in benefits now received by the group under various FEHBP plans, then the total cost for both programs would be the same as current FEHBP costs are now. The more difficult policy issue to resolve would be the proper share of the premium that would be paid by the Federal Government and by annuitants. If annuitants in the new option paid less as a group than they do now, either Federal costs would rise, or the cost would have to be redistributed to other FEHBP enrollees through lower benefits or higher premiums.

What is an annuitant's right with respect to group health insurance?

It is sometimes argued that Federal employees "subsidize" the health care costs of Federal retirees, because the costs of the latter group are higher, thereby increasing costs paid by the former. However, the cost to FEHBP of annuitants covered by Medicare are actually lower than those of the average worker. Thus, some annuitants covered by Medicare argue that they subsidize everyone else because they continue to pay full FEHBP premiums after their benefits are largely paid from another program.

Federal annuitants participate in FEHBP only if they were first Federal employees. To the extent that these retirees earn the right to participate in FEHBP as part of their compensation, that right cannot be fairly challenged on the grounds that their participation causes difficulties for the program. While that right could be challenged directly, no argument has been advanced to suggest that it should be. Proposals to solve problems that retiree participation causes for FEHBP, its plans, and other participants, should be predicated on their effectiveness as solutions for all parties, rather than on the extent to which they correct program difficulties at the expense of annuitants.

Nor can it be argued that subsidization of one group by another is necessarily grounds for adjusting the program's design. Group health insurance presumes substantial "cross-subsidies," and sorting out the relative weight of the subsidy each possible category of participant carries is contrary to that philosophy. Retirees without Medicare are subsidized by both workers and retirees covered by Medicare, and the last group subsidizes both of the other groups but to different degrees. In the life cycle, a given person normally moves between groups that provide subsidies to ones that receives them.

To speak of these subsidies is to speak of groups and not individuals. Actual enrollee premiums are paid by individuals. To the extent that some individuals in FEHBP subsidize others, then the greatest subsidy "disadvantage" accrues to the individual fortunate enough never to have the need to use the benefits paid by those premiums.

C. Costs

In recent years, much attention has been paid to the growing costs of FEHBP. At lower income levels, pay and annuity adjustments usually given each year to reflect changes in the cost of living have largely been consumed by increases in health insurance premiums. Because of concern about the Federal budget deficit, the Administration has proposed a change in the way the Federal share of the premium is calculated which would shift more of the cost of the program to participants. Others suggest that reform of the program could save money as well as improve the program's effectiveness. This section examines FEHBP costs, what affects their magnitude and growth, and how costs might be affected by program reforms.

Factors affecting group health insurance costs.

A variety of factors affect FEHBP costs:

Eligible population. Federal employees, retirees, and their eligible dependents constitute the population covered by FEHBP. Not only is the number of persons participating an important factor affecting costs, but so too is their use of health care services. There are a number of demographic and other characteristics that are used as surrogates for utilization: age, sex, family size, region of the country, have an important bearing on program costs.

Use of medical services. The health status of the population varies considerably, and so then does the amount of services used by that population.

To some degree, use of services may be accounted for by the demographic profile of the population, but not entirely. Other factors that affect a person's decision to seek treatment are also important, such as knowledge about health care, resources to pay for treatments, and the habits and preferences of health providers ("practice patterns"). Thus, as an intended effect, insurance encourages the use of services by providing a means for their payment, which then must be balanced against the probability that unnecessary use of services will also occur.

Plan benefit provisions. FEHBP plans vary in the services they cover and in the extent to which they pay the costs of services they cover. Plans may limit payments to charges they deem "reasonable and customary" in the locale in which the service is performed, or make payments according to a fixed schedule. Plans also vary in the interaction between deductibles, coinsurance, patient copayments, and maximum out-of-pocket limits.

Overhead and administration. In addition to the cost of paying claims for services, plans have costs for processing claims, maintaining reserves, paying premium taxes, and accounting for other overhead expenses. FEHBP plans also charge a small amount as payment for a presumed level of risk in FEHBP plan operations ("risk charge" or "profit").

The cost of a group health insurance plan is derived from several components. Ultimately, the costs of a group health insurance plan include the claims filed; less coinsurance, deductibles, copayments, and charges in excess of payment limits deemed reasonable by the carrier; plus expenses for administering the plan; and any required reserves or other expenses. The premium is this total amount divided by the number of enrollees in the plan.

By far the largest share of plan premiums is devoted to the payments made for the services performed. Thus, significant impact on costs is achieved only if changes are made in the amount of covered services used, or in the payments made for the charges attached to the services provided.

Are FEHBP costs too high?

In order to evaluate the cost of FEHBP, it is helpful to compare its costs against some alternative.

- Although in recent years FEHBP premiums have increased dramatically, the rate of increase in average FEHBP premiums through the 1980s is similar to the growth in premiums in private sector plans.

During each of the last 3 years, FEHBP premiums have increased on average by 20 percent. Over the last 9 years, FEHBP premiums have grown by an average of 12 percent annually. However, special circumstances held down premiums, in 2 years--1982 and 1986. Despite year-to-year differences, the cumulative increase in FEHBP premiums would be nearly the same as that experienced by private sector firms were it not for the substantial cost shifting to participants in 1982.

In 1982 OPM instructed FFS plans to reduce their benefit costs by 13 percent. This reduction was primarily accomplished by the introduction into these plans of various copayments and deductibles. This implementation of cost shifting reduced by half what would have been an average increase in 1982 in FEHBP premiums of 35 percent. In 1986, concern about growing reserves caused plans to draw them down. This resulted in a $1 billion rebate plus an average reduction in the 1986 premiums of about 11 percent.

Other factors also affect the growth in FEHBP premiums. About one-half of the increase in FEHBP premiums has been caused by increases in medical care services costs. About one-fourth has been caused by a net increase (400,000) in the number of annuitants in the program which, because of the increase in average age, also caused average utilization to increase. Some of the remaining one-fourth of the increase is attributable to the ebb and flow of various cost recovery and reserve building that occurs each year. Finally, utilization patterns for health services change with both the introduction of new forms of medical technology and changes in opinions about the effectiveness of specific treatments.

- The typical FEHBP plan is less generous than the typical private sector plan, when measured against a standard Federal population.

The team computed the pure premium[2] cost of a typical FEHBP and private sector plan, as if those plans were applied to a population representative of FEHBP participants. The difference in the cost of the two plans is about 15 percent, primarily caused by the more generous dental benefits, mental health coverage, and generally lower enrollee cost-sharing requirements in private sector plans.

Another way to compare the value of FEHBP coverage is to treat the Federal payment to FEHBP as a form of compensation. The average annual Government payment for employee health insurance is $2,861. The comparable private sector employee earning $30,000 (the average Federal salary) receives an employer health benefit worth $3,960 (a difference that equates to from 3 to 7 percent of Federal pay). After weighting for differences in retiree coverage, the private sector value of employer-paid health coverage exceeds the FEHBP payment by 38 percent, an advantage that increases for workers at higher salaries in the private sector.

Most of this difference is accounted for by the different methods for meeting the total plan premium. In general, the practice in the private sector is for the employer to pay 100 percent of the premium for the employee, and about 75 percent of the premium for any dependents. The employer can deduct these payments from the firm's taxable income as a business expense. If private sector employees were to pay these premiums, they would have to use after-tax income, as Federal employees must in paying their share of FEHBP premiums. Thus, in the private sector, there is an incentive for workers to accept lower wages in return for employer-paid health insurance, if the gross value of the foregone wages is roughly equal to the employer share of health insurance costs.

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[2] Pure premiums are determined by dividing the total cost of benefits by the number of persons in the covered group. Excluded are amounts for reserves, premium taxes, administration and overhead.

The premiums FEHBP enrollees pay tend to vary by their age and income, as a result of the types of plans to which they tend to gravitate. Among active workers (including postal workers), the average premium of the plans in which workers are enrolled tends to increase with age, even after controlling for workers' pay levels. Also, within each age group, higher-paid Federal workers, on average, choose plans with premiums that are higher than the plans that lower-paid Federal workers choose. However, FEHBP premiums, as a percent of enrollee pay, are higher on average for lower-paid Federal workers, in spite of the fact that lower-paid workers tend to be enrolled in lower-cost plans.

Would adopting cost control measures save money?

As health care costs have risen, many employers have sought ways to restrain that growth. Some savings are achieved by developing more efficient administrative procedures and reducing or avoiding costs associated with other aspects of providing insurance. Generally, however, reducing health insurance costs requires changing either the amount of services that are provided to the group or the payments that are made for services.

Employers have introduced methods by which the participants are made to share in the costs incurred beyond the actual employee premiums. Several strategies for achieving these ends have been incorporated by some FEHBP plans. Some of these cost-saving efforts have been undertaken by the plans themselves, while others have been required by OPM in an effort to reduce Federal costs.

- A package of plan-based cost control measures is generally thought to save money in private sector plans.

Private sector vendors of health insurance plans do give credit toward the computation of a premium if the plan has incorporated a common package of cost control measures, although some analysts doubt that they can reduce costs substantially. OPM has encouraged FEHBP plans to adopt these techniques. While a few plans have incorporated some of these approaches, adoption of utilization controls (case management, preadmission certification, second surgical opinions, outpatient surgery, alternative services, etc.) is not uniform throughout the program because of its possible dampening effect on plan enrollment.

- Costs could be saved on certain administrative expenses, although more efficient administration could also increase other costs.

Certain fees required for the operation of FEHBP do not directly bear upon the relationship between medical services and costs. For instance, plans are required to include in their estimated premiums, amounts for reserve funds. These reserve levels are theoretically intended to guarantee the security of the insurance rights purchased through each plan. Yet, because the Federal Government has assumed the responsibility for assuring the continuation of this program, actual reserve levels do not increase the security of the insurance.

Furthermore, because FFS plans must set premiums to recover their losses, their actual financial risk is limited to the possibility that the program would terminate. Thus, risk charge amounts included in the premium could be eliminated if the Government explicitly accepted the risk by defining FEHBP as self-insured.

Finally, the extent to which each plan allocates a portion of revenues for claims processing varies from 4 percent to nearly 13 percent. Certainly, aggressive administrative efforts could return dividends if the additional effort were applied to claims review or to attain greater efficiency, but savings from these additional administrative efforts would be hard to quantify. GAO is currently examining FEHBP to determine ways in which better administration of the program could save money.

- The consumer power of the FEHBP population could be unified.

Group health plans have frequently shown savings in plan costs by contracting with medical service providers. In return for encouraging participants to use the favored providers, those providers grant discounts to the plan. Indeed, many systems of health insurance (PPOs, HMOs) depend on one variation or another of these arrangements in order to compete with plans that give participants a wider choice in the selection of providers. Such plans could return these savings to the insurance purchaser in lower premiums or more extensive coverage.

The Federal Government is the largest purchaser of employee health insurance in the United States. It is conceivable that discounts and other advantages could flow to FEHBP if the program were to negotiate fees as a group. In the present arrangement, Federal workers and retirees are not always able to exercise sufficient consumer power to generate discounts.

- The most aggressive form of control would directly affect provider services and/or payments.

Directly limiting the payments that the plan would make to hospitals, physicians, and other health service providers is advocated by some analysts of health care cost containment efforts. Medicare has implemented a "prospective payment" system that sets payments for inpatient hospital services based on the diagnosis of the patient. Medicare has also frozen fees to physicians for a limited time period, and directly reduced the payment levels of some procedures designated as overpriced.

The most direct method of controlling costs involves limiting the volume and intensity of services. Some concern exists because such an approach entails the exercise of medical judgments by persons other than the provider. Many plans already incorporate "gatekeeper" approaches that are intended to diminish the provision of unnecessary services. Further effort to restrict services requires the development of guidelines, against which the appropriateness of particular services could be determined.

Adopting these approaches would require the development of an extensive data base, along with methodologies for evaluating the appropriateness of particular services in defined situations. Whether this expertise will emerge with sufficient reliability to be effective as cost containment, while at the same time maintaining an acceptable level of quality in the provision of medical services, is as yet uncertain.

Would reform of FEHBP structure save money?

Some critics of FEHBP advocate major structural reform as a way to save money, expecting to find in the present design some characteristic that exhibits unreasonable costs.

For instance, some have suggested that the existence of choice in FEHBP adds to program costs, as participants move from plan to plan in an attempt to match benefits with expected needs. While some migration in search of particular benefits does exist, the team found that its impact on overall program costs is insignificant. Most migration is in pursuit of lower premiums. Some of these "premium shoppers" choose plans in which the actuarial value of benefits is less than that of the average FEHBP benefit package. Thus, rather than cost money, choice actually leads some enrollees to elect lower-cost plans that expose them to larger financial risks.

Choice does raise the amount of FEHBP premiums paid by the Federal Government because of the operation of the Big Six formula (60 percent of the unweighted average of the six plans). Because two of the plans in the Big Six are affected adversely by risk segmentation, the standard Federal contribution to FEHBP plans increases when premiums for those two plans rise. The formula could be modified to account for this effect, but reducing the Federal cost without changing the program simply shifts costs to the participants.

Program reform will not save money unless coupled with benefit reductions, higher costs for at least some participants, or direct program limitations on the discretion with which health care providers prescribe services and receive insurance payments. For instance, consider the following factors:

- About 16 percent of the employees eligible to participate waive health coverage and forfeits the Federal contribution to the program. If a reformed program became more attractive, some of these nonparticipants would elect coverage.

- About 500,000 annuitants do not participate. Some consideration might be given to granting an opportunity for these annuitants to join the reformed program.

- Some potential FEHBP enrollees are not covered by any health insurance. Congress has also been interested in extending health coverage to uninsured Americans. That interest could translate into pressure to include these noncovered Federal workers and retirees in any reform effort.

- Pressures for reform could lead to improvements in the treatment of some program participants. Unless the price for improvements were met by a corresponding decrease in the value of coverage for others, then such improvements would have net costs.

III. STRATEGIES FOR REFORM

In chapter 3, a methodology for analyzing alternative means of reforming FEHBP is demonstrated. That analytic framework examines FEHBP issues in the context of general strategies, with variations in the specifics of those strategies compared. The strategies are not recommendations, or proposals. They are illustrations of the methodology and a way for FEHBP issues to be examined in a context of perceived problems and possible solutions.

Each strategy is made up of six components, and each component includes several variations. Three general strategies are examined:

- A package of changes to the current program.

- A new program, restructured to provide multiple choices within a controlled environment.

- A new program, structured to resemble the plans typical of large firms.

Strategy 1: Changes to the Current Program

Strategy 1 presumes that the current program needs adjustments, but that reforms should retain the essential characteristic of participant choice from among existing plans.

Benefit design. Confusion among alternative packages could be eliminated if more control were exercised over benefit designs. Minimum standards in benefits could be established to eliminate gaps in coverage. A core package could be adopted that specifies benefits which must be offered, supplemented by different packages of additional coverage. The most certain control over benefit packages would entail specifying all benefits that could be offered.

Cost controls. OPM currently encourages plans to include cost control measures, but has not established common plan requirements. Cost controls could be required of each plan, or minimum standards for cost controls could be set. Data collection could be standardized and expertise developed to monitor effectiveness of these controls. The most aggressive form of cost control would reduce the volume of services or payments by placing controls on the providers.

Enrollee choices. Permitting enrollees to choose among a large number of plans is thought to lead to FEHBP's most difficult problems. Restricting those choices, either by reducing the number of plans and/or by limiting employee organization plans to members, could diminish choice-related problems. The tendency for risks to congregate in particular plans would diminish, especially if the eliminated plans were those in which similar risks have congregated.

Premium sharing. The current formula for determining the dollar amount paid by the Federal Government for each plan's premium, in conjunction with risk segmentation, causes the Federal percentage of program costs to rise. However, because of risk segmentation, that increase is not shared evenly among the enrollees. This issue can be addressed by a combination of changes. First, the Federal payment percentage could be frozen at its current level, or a "weighted average" formula could be adopted that would neutralize the effect that certain plans now have on the formula determining the Federal share. In addition, the Federal payment for each plan could be designed to reflect risk variations within plans, or enrollee premiums could be set by linking them to the value of different benefit packages measured against a common standard.

Treatment of annuitants. Many retirees are spending more than they are likely to "need" for adequate health insurance. Some retirees believe they are unfairly treated because of the overlaps in coverage between FEHBP and Medicare. Separate plans specifically tailored to the circumstances of retirees covered by Medicare could be designed at different levels of generosity. Retirees age 65 and over but not eligible for Medicare could be brought into that program.

Financing. Because plans are able to recover prior year losses by increasing premiums, the Federal Government is effectively self-insuring FEHBP. Nevertheless, the method by which reserves are developed has an effect on premiums. FEHBP could more explicitly self insure, and the practice of requiring each plan to include a specific insurance component within its annual premium rate could be eliminated. The Federal Government could also eliminate other charges included in the premium rate, such as State government premium taxes.

Strategy 2: A New Multiple Choice Plan

If it were concluded that the current program structure should be changed, then a new program could be designed that retains some aspects of the current program. This new program could retain some variation in plans, but operations could be more directly controlled.

Benefit design. The number of different benefit packages could be strictly limited. As in *strategy 1*, the designs could be restricted by setting minimum standards, requiring a core package with alternative supplements, or specifying all benefits that could be offered.

Cost controls. The issues in cost controls in *strategy 2* are not significantly different from those in *strategy 1*. The greater central program authority implied for *strategy 2* might make it easier to establish more direct reviews over the payments and provision of services in HMOs.

Enrollee choice. For purposes of illustration, *strategy 2* is analyzed as if the choice among plans were limited to one core benefit package for the FFS plans and three different levels of supplements. The cost projections in chapter 3 assume that the Federal Government would pay 100 percent for Self Only and 75 percent for Family coverage. The supplements could include dental and prescription drug coverage, and additional mental health benefits. The number of HMOs could be limited or expanded.

Premium sharing. *Strategy 2* implies direct control over the conditions under which multiple choice among plans occurs. The amounts paid by participants could reflect the value of benefit package differences (measured against a common standard), or the Federal payment for each plan's premium could reflect the differing risks among the populations enrolled in each plan.

Treatment of annuitants. As in *strategy 1*, the principal alternative treatment of annuitants would be to design a package especially for the population covered by Medicare. *Strategy 2* also requires determining the level of coverage and Federal subsidy in these separate retiree options.

Financing. Inherent in the design of *strategy 2* is a self-insured FEHBP. State premium taxes could then be excluded from the premium cost.

Strategy 3: A Typical Private Sector Approach

In most firms in the private sector, employees participate in one FFS plan or they can choose to enroll in a selected HMO. The employer pays most of the premium costs. Private sector plans differ considerably in design and generosity of benefit packages, but on average they are more generous than the typical FEHBP plan.

Benefit design. As is typical in the private sector, only one FFS plan is offered. For purposes of analysis, the design of this plan follows typical private sector practice.

Cost controls. The design of the plan would entail specifying the cost controls required. The design and operation of participating HMOs could be aggressively administered. The single plan approach could facilitate direct controls on provider services and payments, and a unified FEHBP population could be a potent consumer force.

Enrollee choice. In typical private sector plans, choices among HMOs are limited. Some employers make an effort to centrally coordinate HMOs participating from different regions.

Premium sharing. Projected costs for *strategy 3* assume full Federal employer payment for employees and 75 percent payment for dependents, the typical private sector practice. The Federal contribution to HMOs could be equal to the dollar amount that would be paid to the FFS plan, with regional adjustments possible.

Treatment of annuitants. As was mentioned in previous examples, the principal treatment of annuitants involves creating a separate plan for those retirees also covered by Medicare. The Federal contribution to that separate plan could be determined on the same basis as the Federal share of the basic FFS plan or an alternative level of premium sharing could be established.

Financing. This strategy assumes that the Federal Government, like many large employers, would self insure the program. Reserves would not be necessary, although Congress could devise a method to assure the payment of claims independent of the annual appropriations process.

CHAPTER 2. BACKGROUND

The Federal Employees Health Benefits program (FEHBP) is the largest employer-based health insurance program in the United States, insuring almost 9 million workers, annuitants, and their dependents in 1989.[3] FEHBP is perceived to have a number of problems arising from: (1) the freedom of enrollees to choose their health care coverage yearly from among numerous competing plans; (2) the program's method used to cover annuitants; and (3) rising health care costs, and it is thought by many that reform is needed. This chapter provides background information to clarify the issues facing FEHBP.[4] First, it briefly describes FEHBP. Second, it discusses basic health insurance concepts, health care financing and delivery, and health plan benefit design and cost controls. Finally, it describes the methodology used by the FEHB Team to analyze FEHBP issues and reform.

I. THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

In 1959, the Federal Government created FEHBP to eliminate the disparity in benefits between the Federal Government and private employers as well as to attract and retain competent employees. Authorized by the Federal Employees Health Benefits Act (FEHBA) of 1959 (P.L. 86-382), FEHBP provides voluntary health insurance coverage to Federal employees, annuitants, and their dependents. In 1989, FEHBP covered almost 9 million employees, annuitants, and dependents out of a possible 10 million total Federal employees, annuitants, and dependents at a total program cost of approximately $11.6 billion. The following section briefly provides general information on enrollment, treatment of annuitants, the types of health plans available under FEHBP and their benefits, the financing of FEHBP premiums, and FEHBP administration.

A. Enrollment

The FEHBP covers most civilian Federal employees, annuitants and their dependents. Employees and annuitants enroll in FEHBP voluntarily. In 1989, about 72 percent of Federal employees and annuitants are enrolled in FEHBP. The remaining 28 percent are either ineligible or have waived FEHBP coverage.

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[3] Estimated numbers of insured dependents are based on a March 1988 Current Population Survey by the U.S. Bureau of the Census.

[4] Additional background information on FEHBP not covered in this chapter can be found in the appendices. For a detailed overview of FEHBP, its legislative history, and characteristics of FEHBP enrollees, see appendices B, C, and H, respectively. In addition, for a list of acronyms and a glossary of health insurance terms used throughout the report, see appendices B and C, respectively.

An individual may enroll in Self Only coverage, or may enroll in Self and Family (hereafter referred to as "Family") coverage, which covers the employee or annuitant and his/her dependents. Employees and annuitants may change enrollment during an annual open enrollment period ("open season"), at which time they may switch plans.

B. Treatment of Annuitants

Retired annuitants enroll in FEHBP in the same way as employees and pay the same premiums. However, in 1988 about one-half of participating annuitants also received Medicare coverage, which pays first for some of their medical expenses; FEHBP then pays for most expenses not covered by Medicare. In addition, FEHBP plans waive deductibles and coinsurance for enrollees with Medicare coverage.

C. Types of Plans and Options

The FEHBP authorizes funding for three types of plans: (1) two "Government-wide" plans which have been offered by Blue Cross/Blue Shield (BC/BS) and Aetna Life Insurance Company, respectively, since FEHBP began; (2) employee organization plans sponsored by Federal employee organizations and unions, which charge an annual membership fee (e.g., $30) to join; and (3) comprehensive medical plans, also known as health maintenance organizations (HMOs), which are prepaid health plans that provide care using designated physicians and hospitals. Some plans have both "high" and "standard" options[5] offering different levels of coverage; the Government-wide plans are required by law to have both levels of benefits. Except for HMOs, new plans cannot enter the program without an act of Congress.[6]

Not all plans are available to all employees or annuitants. Both of the Government-wide plans and most employee organization plans are available to everyone, but a few employee organization plans are open only to certain groups of enrollees. Comprehensive medical plans are not nationwide plans. They serve only certain geographic areas (primarily urban areas) and, therefore, are available only to enrollees who live in these areas.

In 1989, there are about 450 options in FEHBP. Of these, four are the Government-wide options--BC/BS High and Standard Options, and Aetna High and Standard Options, 26 are sponsored by employee organizations, and about 420 are options under comprehensive medical plans. The Government-wide and employee organization plans each enroll about two-fifths of all enrollees and the comprehensive medical plans enroll the remaining one-fifth.

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[5] Although a plan may have two "options," each option operates as a separate plan with enrollees able to switch options only during open season. Hence, the terms "plan" and "option" are often used interchangeably.

[6] This last occurred with the enactment of P.L. 99-53 which allowed certain new employee organization plans to enter the program.

D. Benefits

Although FEHBP plans offer a range of health benefits, most offer coverage of hospital, surgical, physician, mental health, prescription drug, emergency care, and "catastrophic" benefits. However, the plans vary with respect to the amount they pay for each benefit (coinsurance and deductibles), the availability of other benefits, such as dental care, and the extent to which they expose enrollees to the risk of "catastrophic" medical bills.

E. Financing

The Federal Government and the enrollee jointly pay for the cost, or premium, of the plans, according to a statutory formula. The Government's portion of each enrollee's premium is a *fixed* dollar amount equal to 60 percent (calculated separately for Self Only and for Family coverage) of the average of the ***high*** option premiums for the following plans, commonly known as the "Big Six" plans: (1) the two Government-wide plans, BC/BS and Aetna; (2) the two employee organization plans with the largest number of enrollees (in 1989, GEHA and Mail Handlers); and (3) the two HMOs with the largest number of enrollees (in 1989, Kaiser of Northern California and Kaiser of Southern California). The Government contribution cannot exceed 75 percent of the cost of any plan's premium. In 1989, the Federal Government pays approximately 67 percent of the average cost of premiums for employees (*except* U.S. Postal Service (USPS) employees) and annuitants. The employee or annuitant pays the balance.

USPS, under a collective bargaining agreement negotiated with its employees, pays a higher percentage of the health benefit total premiums than does the Federal Government. The USPS share is 75 percent of the Big Six average, not to exceed 93.75 percent of any plan's premium. In 1989, the USPS share, on average, is 87 percent of the total premiums for USPS employees. Postal annuitants are not covered under this agreement but receive the same Government contribution as do nonpostal enrollees.

Overall, the combined Federal Government and USPS average contribution for both nonpostal and USPS employees and annuitants is 71 percent in 1989.

F. Administration

The Office of Personnel Management (OPM) administers FEHBP. OPM negotiates yearly with plans to determine benefits and premiums for the following year, manages the FEHBP premium payments, approves qualified plans for participation in the program, and determines the times and conditions under which the open enrollment period will take place.

II. PRINCIPLES OF GROUP HEALTH INSURANCE

Health insurance is generally purchased through a group that exists for some purpose other than buying insurance, such as a workplace, labor union,

or professional association. In the United States, most people under age 65, including Federal workers, receive their health insurance through their employers as a fringe benefit. In 1986, two-thirds of the nonelderly population, including workers and their eligible dependents, received their health insurance through employer-based plans.[7] From the covered individual's perspective, group insurance such as employer-based insurance, has two advantages over individual coverage. First, if the group is a large one, there will be enough individuals who are low users of health care to help pay for those who are high users. Second, for those covered through their job, the employer usually pays for part, if not all, of the cost of the insurance coverage, although the trend is to require workers to share in the cost. This section briefly provides background on group health insurance.

A. Risk and Predictability

Insurance protects individuals against financial loss resulting from unexpected hazards or risks. Except in the case of health insurance, most insurance covers occurrences (e.g., fire, theft, auto damage), that the individual is often unable to predict. Health insurance differs from other kinds of insurance in that it serves two purposes: it is a way to protect against financial loss from unpredictable and catastrophic medical expenses, but it is also used to budget for predictable expenses as well. While there are many medical expenses that result from entirely unpredictable events, such as injury resulting from an accident, there are other expenses that are predictable, such as monthly refills of prescription drugs for an illness needing ongoing treatment (e.g., hypertension).

Another unique quality of health insurance is that, while other kinds of insurance cover predetermined losses for well-defined risks (e.g., the cost of rebuilding a house destroyed by fire), health insurance covers undetermined losses for ill-defined risks that are always changing. In health insurance, risk is ill health and loss is the expense to restore health or at least achieve maximum well-being. However, maximum well-being is a state that is not strictly defined and continually changes not only because individual consumers of health care have varied demands regarding necessary and appropriate care, but also because physicians' diagnoses of illness and prescriptions for treatment are continually affected by medical judgment and ever-expanding medical knowledge and technology.

B. Cross-Subsidization and Risk Segmentation

In theory, group insurance spreads the losses (or expenses) of a few people among the many through cross-subsidization. This cross-subsidization occurs through the payment of a common "premium" that reflects the per capita share of the costs of health care for the entire group (e.g., the employees of a corporation). In the case of health insurance in general, healthy persons generally subsidize the medical costs of the sick. Without these cross-subsidies, those who are high users of health care would face exorbitant medical costs.

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[7] U.S. Congress. House Committee on Education and Labor, House Committee on Energy and Commerce, and Senate Special Committee on Aging. *Health Insurance and the Uninsured: Background Data and Analysis.* Committee Print. Washington, May 1988. p. 95.

In the marketplace for health insurance, forces often disturb this cross-subsidization. Insurers competing for a share of the health insurance business, and individuals seeking to minimize their health care costs while at the same time seeking health services appropriate to their needs may, to the extent they can assert themselves in the marketplace, and upset this cross-subsidization by gaining individual advantage relative to others in the group. "Risk segmentation"[8] is one way in which cross-subsidization can be disrupted. In an environment such as FEHBP, where individuals may choose yearly among competing health plans, risk segmentation occurs when low users of health care ("low risks") and high users of health care ("high risks") congregate in different plans. Because a plan's premium reflects the use and, therefore, cost of health care of the covered group, plans where low-risk individuals have congregated will cost less than if risk segmentation had not occurred. Hence, the congregation of low risks in a plan is sometimes called "favorable selection." Conversely, the congregation of high risks in a plan is often referred to as "adverse selection" because the cost of these plans will be higher than if risk segmentation had not distorted the cross-subsidies inherent in group insurance.

The process of risk segmentation may begin when low and high risks are attracted to different plans that offer benefits appealing to different risk groups. For example, low-risk individuals may be attracted to "low" or "standard" option plans because they do not believe they will need much health insurance coverage and want to pay the lower premium associated with a plan with lower benefits. High-risk individuals who anticipate using substantial medical services may be attracted to the "high" option plans because of their more extensive coverage. Risk segmentation can also occur when competing health plans whose benefits have been designed and marketed to attract low-risk individuals draw out such individuals from other plans. Once this process has begun, a "risk spiral" can occur--as low risks leave a plan (or plans) it becomes more heavily concentrated with high risks, thus driving up premiums. As premiums increase, low risks may become unhappy with the higher premiums and seek a lower-cost plan. This causes additional low risks to leave, further escalating the costs of the plans with high risks.

C. Premiums

Health insurance premiums equal the cost of providing health benefits to a group. Except for administrative costs, differences in premiums among health plans reflect differences in plan benefits or differences in the use of health care by the covered group. Individuals in a group vary in how much health care they use; the variation is often associated with such factors as the age, sex, or income of the group's members, and the geographic area where the members live. Premiums for identical health plans for groups with high utilization patterns will cost more than for groups who use less health care.

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[8] The terms "risk segmentation," "risk selection," and "biased selection" are often used interchangeably.

In addition to the benefits offered and the characteristics of the covered group, health plan premiums also reflect administrative expenses. Administrative expenses include costs of processing claims, general administrative expenses, interest received on reserves held for unexpected claims, risk charges,[9] profit, and premium taxes assessed by States.

There are a number of ways that insurers can calculate premiums for a group, but most are variations of either "experience rating" or "community rating." Whether experience or community rating is used depends on a number of factors, including the size of the group to be insured, certain laws governing health insurance, competition for groups among insurers, and the desire by low-cost groups to insure at the lowest premium possible.

When using experience rating, an insurer typically charges a premium that reflects the past claims experience of the employees (e.g., the cost of covered health care services used by the employees), which is a statistically reliable way of estimating expected claims. When using community rating, the insurer charges a premium that is the average of the estimated claims experienced by all employers (or "classes" of employers, such as specific industry groups) in the geographic area--the "community." Under a community-rating scheme, employers with below-average claims experience subsidize employers with above-average costs.

Competition in the health care marketplace has led insurers to expand their market share by experience-rating employers with below-average costs who find an experience rated premium a better buy than a community-rated one. While the move toward experience rating may be a natural outcome of competitive pressures, some have asserted that this disrupts community-wide cross-subsidies and may leave some high-risk groups with exorbitant premiums as low-risk groups leave the "community" to become experience rated.

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[9] A risk charge is a fee assessed on the insured group by the insurer to protect against loss if the group were to end the insurance contract with the insurer in a deficit position.

Except for HMOs, most employer-based health insurance plans are experience rated.[10] In FEHBP, the Government-wide and employee organization plans and some HMOs are experience rated. About 90 percent of FEHBP HMOs are community rated and about 10 percent are experience rated.

III. HEALTH CARE FINANCING AND DELIVERY ARRANGEMENTS

A number of different arrangements have developed to finance health care services, in response to both competition for employer-based business and concerns about the growth in health care costs. Traditionally, employers have purchased insurance plans offered by commercial insurers and by BC/BS plans, which then pay health care "providers" (hospitals, physicians, pharmacies, and laboratories) for each service rendered to the plan's enrollees. The term used by OPM and by others for this type of plan, and the term that will be used in this report, is "fee-for-service" (FFS) plan.[11] This term is used to contrast traditional health insurance with another type of arrangement, known as a "health maintenance organization" (HMO), which provides both the financing and the delivery of comprehensive health care services for a prepaid, fixed, per capita fee. A recent variation in FFS financing is the "preferred provider organization" (PPO). In addition, hybrid arrangements of these insured arrangements have developed.

In FEHBP, the Government-wide plans and employee organization plans are FFS arrangements, while the comprehensive medical plans are HMOs. Some FEHBP FFS plans incorporate limited PPO arrangements.

These three arrangements are distinguished primarily in the way health care providers are paid for their services, the extent to which the use of health care is controlled, the degree of choice individuals have in selecting their providers, and the degree to which the insured must pay for their health care out-of-pocket.

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[10] The prevalence of community rating by HMOs reflects the requirement by the Health Maintenance Organization Act of 1973 (P.L. 93-222), as amended, that federally-qualified HMOs use a form of community rating. Federally-qualified HMOs are those that meet certain Federal standards and requirements for operation. The majority of HMOs in the United States are federally qualified.

[11] The term "fee-for-service" (FFS) is most technically used to describe a method of billing for medical care under which the provider bills for each individual service furnished to a patient. The term will be used in this report as it is used by OPM and others to describe traditional or conventional health insurance plans in contrast with prepaid systems or HMOs, under which payment to the provider is not directly related to the type or quantity of services actually provided. Use of the term "FFS" to refer to all traditionally insured plans disregards the variety of provider billing and payment arrangements that exist under such plans.

In contrast to the insured arrangements just mentioned, many larger employers have chosen to "self insure," or pay for the medical bills of their employees themselves rather than paying an insurance company, an HMO, or another insuring arrangement to do so. The following briefly discusses these various financing arrangements.

A. Fee-for-Service Arrangements

Since the rapid expansion of employer-provided health insurance during and after World War II, FFS health insurance has been the primary way in which employers have provided health benefits coverage to their workers. FFS insurance is essentially a third-party financing mechanism under which the employer contracts with an insurer (or "third party") who then assumes the risk and administrative function of paying claims for the group. Under FFS arrangements, an employer selects or offers a choice of health insurance plan(s) for his employees and pays all or part of the premium to the insurance carrier. The enrollees receive medical care from their choice of health care providers.[12] The providers are then reimbursed for each service by the carrier using one of many different payment designs. The plan usually charges the enrollee for a portion of the cost of health care services received.

Because FFS plans generally have little control over the enrollee's choice of health care providers and the quantity and cost of the care they will receive, FFS insurance is often thought to lack incentives for providers and enrollees to control health care utilization and costs. In recent years, however, some insurance carriers have established procedures to restrict utilization of inpatient hospitalization and surgery.

In 1989, FEHBP contracted with 22 FFS plans (with a total of 30 options), including the 2 Government-wide plans and the 20 employee organization plans.

B. Health Maintenance Organizations

An HMO is a type of health insurer that provides medical care for its enrollees in return for a per capita premium. The HMO's premium, like the premium for a FFS plan, is a fixed amount calculated to cover whatever amount of the defined set of benefits the enrollees need during the contract period.

However, unlike FFS insurers which simply pay provider bills incurred by their enrollees, HMOs are responsible for actually providing the medical care, either directly or through contractual arrangements, using affiliated physicians, hospitals, and other providers. HMO enrollees (who must live within the HMO's enrollment area) agree to obtain all services, except emergency and out-of-area care, from the HMO or its affiliated providers. The

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[12] Plans do restrict coverage for certain types of providers. For example, chiropractic services are frequently excluded from coverage.

HMO is not financially responsible for unauthorized nonurgent care obtained outside the organization. Thus HMO enrollees are "locked in" to the HMO's providers, unlike FFS enrollees whose provider choices are generally unrestricted.

HMOs typically cover a more comprehensive range of services than do FFS plans, including preventive services such as immunizations and annual physicals. HMOs provide these services with little or no enrollee cost sharing, thus removing the financial risk faced by enrollees in some FFS plans that require significant cost-sharing amounts (resulting from, for example, deductibles, coinsurance, limits on provider charges, or plan maximums).

Although there are a variety of ways that HMOs structure their organizations, HMOs have an incentive to control health care use, and thereby costs, because providers are at financial risk to keep the cost of care for each enrollee below the premium. The HMO can manage enrollees' use of services and can select low-cost providers or negotiate discounted rates. However, others have argued that in order to control costs, HMOs also have the incentive to provide minimal services, perhaps affecting the quality of care. Others suggest that HMO premiums can be competitive with those of FFS plans because they attract younger, low-risk individuals and families who have not formed a long-established relationship with a non-HMO physician and who are seeking coverage of such preventive services as well-baby care.

There are about 420 HMO options participating in FEHBP in 1989.

C. Preferred Provider Organizations

Competition between traditional FFS insurers and HMOs, and among the providers of health care services, has led to the establishment of preferred provider organizations (PPOs). This terms refers to a variety of arrangements where health care providers contract (directly or through an intermediary) with insurers or employers to offer services at reduced rates. PPO arrangements are usually integrated into a FFS plan where the enrollees are allowed a choice of providers, but have an incentive to use the "preferred providers" because enrollee cost-sharing amounts are lower than if they use an unaffiliated provider.

Many employers have found PPOs attractive because of the plan savings due to the discounted provider rates and because their employees have greater flexibility in choosing providers than under an HMO. However, PPO arrangements contain no element to control the use of provider services by enrollees.

Under FEHBP, some FFS plans have limited PPO arrangements in certain geographic areas where enrollees may choose preferred providers that have contracted with the plan in exchange for lower enrollee cost sharing, usually in the form of a lower deductible.

D. Hybrid Arrangements

Some firms that offer a choice between a traditional FFS plan and an HMO allow their employees to move freely between the two plans. Known as "open access," "open ended," or "point of service" plans, these plans offer the enrollee has the option, when he or she needs medical care, of receiving services from an HMO provider with little or no enrollee cost sharing, or of choosing a provider outside the HMO but paying the larger deductible and coinsurance amounts required by the FFS plan. This approach is designed to suit the preferences of employees who desire a choice of providers, while at the same time providing incentives to use the HMO providers, potentially reducing plan costs.

The FEHBP has no open access plan arrangements.

E. Self Insurance

In an effort to contain the costs of their health plans, some employers have taken on some of the functions of third-party insurers, either by "self insuring" or "self administering" their health plans, or both. Larger employers can self insure (or, self fund) their health plans by funding all claims costs themselves, thereby eliminating the cost of an insurance company assuming the risk of insuring the employees. When employers self insure, they eliminate the following costs from the premium necessary to cover their employees' medical expenses: the insurer's profit, State premium taxes required of insured plans, and the cost of benefits that otherwise would be required under State mandated benefit laws.

Employers who self insure their plans still need to process claims and perform other administrative services. Such administrative functions can be provided by third-party administrators (TPAs), or employers can handle this function themselves. TPAs are companies that act as fiscal intermediaries to process claims and provide other administrative services for self-insured plans. Employers can also self administer either a self-insured plan or a plan insured by an insurance carrier.

IV. BENEFIT DESIGN

Health insurance plans pay for the health care services provided to a covered group. Plans vary in the kinds of services they cover and the amounts they pay for those services. FFS plans generally vary more in their coverage of and payments for services, and thus in the degree to which they leave an enrollee exposed to out-of-pocket costs than do HMOs, which tend to provide comprehensive coverage and minimize an enrollee's financial risk. "Benefit design" refers to the way in which health plans specify the services that they cover and the level and arrangements for payment of those services. This section describes the components that make up a plan's benefit design. The focus of this discussion will be on FFS plan design, which predominates in employer-based plans.

A. Covered and Excluded Services

These are the medical services (e.g., hospitalization, surgery, physician services, x-rays and laboratory work, prescription drugs) for which the plan will pay all (or part) of the charges, versus those for which the plan pays nothing. Services not covered by the plan are referred to as "excluded services." Any charges enrollees incur for excluded services are neither paid for by the plan nor applied toward the plan's deductible requirements or catastrophic limits (described below). Examples of excluded services are cosmetic surgery, experimental treatments, and those not deemed "medically necessary" such as those done for educational, research, or vocational training purposes.

B. Enrollee Cost Sharing

Enrollee cost-sharing techniques refer to plan requirements that a portion of a medical bill be paid by the enrollee. Such techniques include the following:

- *Deductibles.* Deductibles are specified amounts enrollees must pay before a plan makes any payments for covered medical services. FFS enrollees are usually responsible for a specified dollar amount of covered charges before the plan pays benefits. For instance, a plan may require that an enrollee pay the first $200 of covered expenses each year. With Family coverage, a separate deductible may be required for each family member, but there is usually a cap on the deductibles required for a family. Most plans require an "overall" or "general" deductible applicable to most services. In addition, some plans require a separate deductible for certain services, such as each hospital admission.

- *Coinsurance.* Enrollees in FFS plans are usually required to pay a portion, usually a percentage, of covered expenses after the deductible has been met. These are referred to as coinsurance payments. For instance, after paying the dollar amount of the plan deductible, the enrollee may be required to pay 20 percent of covered charges, while the plan pays 80 percent.[13]

- *Copayments.* These are specific dollar amounts enrollees must pay for certain services. For instance, a plan may have a $10 copayment for a doctor's office visit. Copayments are more often used by HMOs than by FFS plans.

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[13] Insurance plans define "coinsurance" as the portion paid by the insurer. However, this report will use the more familiar concept of coinsurance as that portion paid by the insured.

C. Limits on Payments to Providers

The benefit design of most FFS plans includes methods for limiting the amount of a health care provider's charges or costs that will be reimbursed by the plan. Commercial insurers usually pay hospital bills as a percentage of the hospital's average charge for a semiprivate hospital room. BC plans limit payments to hospitals by negotiating contracts under which the hospital agrees to accept the BC payment as full payment for the services provided. Most FFS plans limit allowable physician charges for covered services to those defined by the plan as "reasonable and customary" (R&C). Plans then apply their coinsurance rate to the R&C charge for a given service (or to the actual charge, if it is lower). Plans may develop their own R&C limits for physician charges, or they may rely on information collected and maintained by the Health Insurance Association of America (HIAA), a trade association representing commercial health insurers. R&C amounts vary by geographic area to reflect regional differences in medical costs and generally reflect the prevailing charges in the area. However, if a provider's charges exceed the plan's R&C limit, the enrollee must pay not only his coinsurance, but also anything in excess of the R&C limit. For example, if a surgery charge is $1,500, an enrollee in a plan with a 20 percent coinsurance rate and an R&C limit of $1,000 for that surgery will be required to pay not only his 20 percent share of the R&C amount ($200) but also the $500 in excess of the R&C (a total of $700).

Some plans limit payments to providers according to a fee schedule instead of an R&C limit. Under a fee schedule, the plan pays a fixed dollar amount for a covered service; the enrollee is then required to pay the difference between this amount and the provider's actual charges. Unlike R&C's, a scheduled allowance is generally a nationwide amount that averages geographic differences in medical costs. In areas where medical costs exceed the national average, the scheduled amount may be well below providers' charges, thus leaving enrollees without insurance coverage for the difference.

D. Catastrophic Protection

Most health insurance plans offer enrollees protection from "catastrophic" health care expenses by limiting the out-of-pocket expenses enrollees must pay each year for plan deductibles and coinsurance. For instance, an out-of-pocket maximum (sometimes called "catastrophic limit" or "stop-loss limit") of $2,000 means that after out-of-pocket payments made by the enrollee for covered medical services total $2,000, all additional covered expenses are paid by the plan. Plans often exclude certain expenses from out-of-pocket maximums, such as deductibles, expenses for mental health and dental care, and charges exceeding R&C or scheduled allowance limits.

E. Plan Maximums or Limits on Services

These include limits on units of service (e.g., visits or days of care) covered by the plan, or maximum dollar amounts paid by the plan for a service, either per year or over the enrollee's lifetime. For instance, a plan may limit mental health coverage to 30 days of inpatient care per year and limit outpatient mental health care to 50 visits per year, with a lifetime maximum dollar amount of $25,000.

V. COST CONTROLS

As health insurance costs have risen in recent years, many employers have attempted to restrain their costs by shifting a portion of total plan costs to enrollees through enrollee cost sharing or premium sharing. In addition, employers have pressured health insurance plans and providers to incorporate cost control arrangements into their benefit design. Plans try to control costs in different ways, but all techniques attempt to control either the use of health care services or payments to providers, or both.[14] Because players in the health care market may circumvent controls if at all possible to maximize their self-interest, it is sometimes asserted that health care costs cannot be controlled without limiting both health care use and provider charges. This section discusses the following cost control techniques: incentives to reduce the use of health care services and direct controls on payments to providers.

A. Incentives to Reduce Health Care Use

Plans may discourage enrollee use of services through enrollee cost-sharing requirements or by other arrangements incorporated into the benefit design. Enrollee cost sharing provides incentives for enrollees to be more cost conscious in their use of medical services. Deductibles and copayments can discourage the initial use of health services and the filing of small claims. Coinsurance can encourage enrollees to limit their use of services or to seek the least expensive form of treatment. Of course, these plan features also reduce costs for the employer by having the enrollee pay some of the cost of care. However, enrollee cost sharing may also discourage appropriate health care use. High cost sharing might, for example, lead to delays in seeking care.

In addition, plans may incorporate specific arrangements to keep enrollee use of services at the lowest appropriate level. Such arrangements include "managed care," health promotion, and limiting or excluding certain services from coverage. Managed care methods include requiring careful review of inpatient hospitalization to prevent unnecessary hospital use, second opinions for certain surgical procedures, and offering financial incentives for less expensive alternative care (e.g., paying higher percentages for outpatient surgery than for inpatient, or for home health care than for hospital care). HMOs are a form of managed care. Health promotion benefits encourage enrollees to prevent illness through smoking cessation, weight reduction and exercise, for example. Finally, plans can limit or exclude certain services from coverage. For example, a plan might limit outpatient mental health care to a limited number of office visits.

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[14] In addition to health care use and provider charges, administrative costs are also a component of health care costs, but they are small relative to the other components and are not discussed here.

B. Controls on Payments to Providers

In addition to the methods mentioned above, there are other approaches that health plans use to limit the amounts paid to providers. As discussed earlier, both HMOs and PPOs attempt to limit payments to providers. In addition, both Medicare, the Federal health insurance program for the aged and disabled, and CHAMPUS, the health insurance program for military personnel and retirees, use "prospective payment" systems in an attempt to constrain inpatient hospital costs. Under prospective payment, hospitals are paid a predetermined, fixed rate per patient determined according to the patient's diagnosis (or "diagnosis related group" (DRG)). Since hospitals may not bill patients for costs beyond those paid under the DRG system, prospective payments penalize hospitals that fail to keep costs within their payments. Further, since hospitals may keep any difference between the prospective payment and actual cost, there is a financial incentive for hospitals to achieve costs below prospective payment schedules.

VI. METHODOLOGY FOR THE ANALYSIS OF FEHBP ISSUES AND REFORM

The FEHB Team developed a methodological capability with which to analyze and quantify certain aspects of FEHBP issues and possible changes to FEHBP. Central to this methodological capability is a computer model developed by the FEHB Team.[15] The computer model was designed to estimate health insurance premiums and aggregate costs, borne by the Government and enrollees, of the current FEHBP, as well as to model the effect on premiums, costs, and enrollment that might result from changes to the existing FEHBP.

The FEHBP Model provides the means of estimating health insurance premiums or "benefit values", based upon plan features and characteristics of the population being covered by the plan. Based upon insurance company experience, actuaries have established rates which estimate the effects on premiums of certain variations in plan provisions for a standard population. The model uses methods that are similar to those employed by actuaries and insurance underwriters in developing rate books to estimate premiums.

The model is capable of estimating premiums for a wide range of health insurance benefits and provisions. Nearly 50 of the most popular FEHBP plans, representing over 85 percent of total FEHBP enrollment, are coded into the model. A number of plan benefits and provisions capturing the breadth and depth of possible health insurance offerings not necessarily represented by these FEHBP plans are also included in the model.

Benefit values derived from the model are adjusted for the particular demographic characteristics of the Federal workforce, annuitants, and their dependents. Initial benefit values provided by the model reflect the rates that would apply to a representative population of employees and their dependents who receive private, employer-based health insurance. The FEHBP eligible population differs somewhat from the private sector population, in terms of its age and sex composition, region of the country, income, and Medicare coverage of annuitants. Because the cost of providing health insurance is known to differ by such factors, the estimated benefit values are adjusted for the demographic composition of FEHBP participants.

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[15] For a more detailed discussion of this computer model, see appendix A.

Two types of demographic adjustments are made. One adjusts benefit values for the demographics of the overall participating FEHBP population, referred to throughout the report as the standard Federal population (SFP). The other adjusts benefit values for the specific demographic composition of the particular plan. A comparison of estimated benefit values under the two adjustment approaches gives an indication of the extent of "favorable" or "adverse" selection a plan experiences relative to the SFP.

The model's results have been validated against FEHBP plans. The health insurance benefit values of the nearly 50 FEHBP plans selected for detailed analysis were estimated and adjusted for each plan's specific demographic composition. Estimated benefit values from the model were deemed to be reasonable and accurate, after being compared to actual premiums charged by the individual plans.

Modeling alternatives to the current FEHBP entails specification of alternative plan and program structures. The model allows individual plan benefits and features to be specified under an illustrative alternative system, as well as the mix of plans offered. The basis on which the Government's and enrollee's share of the premium is calculated may be readily specified in the model (e.g., current Big Six, proposed weighted average of all plans). It also provides the option of treating annuitants as a separate group, to be costed-out separately under an alternate plan from active workers.

The process by which the FEHBP eligible population might be expected to transfer from the current plan/program structure to a new plan/program structure is also modeled. The model assumes that the eligible population behaves rationally, by enrolling in plans that minimize out-of-pocket costs. It also acknowledges that enrollees do not possess perfect knowledge about the health costs they may incur in any given year, nor complete knowledge about the plan benefits and features from which they have to choose. Persons also differ in their tendencies to expose themselves to the risk of incurring high out-of-pocket expenses. Faced with an alternative plan/program structure to the current FEHBP, enrollees might be expected to select plans that would minimize their out-of-pocket expenses, given their existing level of health care utilization; at the same time, they might also be expected to seek out plans that are most like the ones in which they are already enrolled. The FEHBP Model considers both of these extremes: identifying "inertia plans" in a new program structure with characteristics most like the ones in which participants are currently enrolled, and "movement plans", representing those plans that would minimize out-of-pocket expenses given an individual's current health care utilization level. Transfer rates to the movement plans are highest for those for whom transferring would result in the greatest savings. The possible effect of FEHBP eligibles currently waiving coverage participating in the alternative program is also considered.

After having specified an alternate plan program structure, and having modeled the transfer process, aggregate Government and enrollee costs are tallied and presented.

As part of its analysis, the FEHB Team compared the current program with typical private sector practice by the establishment of a baseline. The baseline is the cost of the existing FEHBP, and it is compared to the cost of a health plan typifying private sector practice that was priced as if it had been adopted for the standard population of Federal employees and annuitants. These two baseline "poles" create a range of costs between those of the existing program and those if FEHBP were reformed to look like typical private sector practice. In addition, the FEHB Team developed, and incorporated into its computer model, two hypothetical health plans representing "typical" FEHBP and private sector plans and priced them for the standard Federal employee and annuitant population. The purpose of developing these typical plans was to compare and quantify the differences in benefit features and costs between FEHBP and private sector health plans and to compare the relative effect of changes in plan benefits.

CHAPTER 3. STRATEGIES FOR REFORM

The purpose of this chapter is to display, in a context of possible changes to FEHBP, the methods for analyzing the issues that would arise if various reforms were proposed.

I. INTRODUCTION

The illustrative strategies for changes analyzed in this chapter were developed to show how analysis of a particular proposal would be conducted using the methodology developed by the FEHB Team. The methodology will yield, for any complete proposal, relevant data on projected annual Government and enrollee premiums, benefit values priced against standard criteria, plan enrollments, impacts on participant expenses, and total program costs. It is important to emphasize that these hypothetical proposals are for illustrative purposes only, and while they are necessarily complete, they are not actual proposals that were advanced to the FEHB Team during the course of the study.

The development of baselines so that proposals can be examined through a consistent set of assumptions requires the specification of all variables affecting the insurance available to a given population. As a particular provision or feature of a proposal is analyzed, it is done with all other aspects of that strategy held constant, unless the alternative is specifically intended to complement an alternative in another component. Because of the interactive effects of features of a proposal, analysis requires complete sets of provisions to be analyzed together.

The specific variations selected for inclusion in this analysis are not exhaustive of those possible, nor is it intended that they be regarded as desirable alternatives in an extensive catalogue that could be examined. They are benchmarks, analyzed to provide common reference for the relative costs and effects of alternatives that could emerge during the development of genuine proposals. These illustrative strategies do constitute a judgment by the team that possible reforms would most likely be proposed within the boundaries encompassed by them. As actual proposals or variations in components arise during the course of committee consideration of reform issues, the team would endeavor to develop comparable analysis of them.

A. Components of the Three Strategies

Three strategies are examined. Each strategy is a complete package, and all features necessary to project its costs and effects are specified in a baseline set of provisions. The three strategies are:

- ***Strategy 1***: A package of changes to the current FEHBP

- ***Strategy 2***: A new multiple choice program

- ***Strategy 3***: A single plan, with supplemental options, patterned after typical private sector practices

Chart 3.1 on p. 65 shows the baseline provisions for each strategy.

Each strategy contains six components: **benefit design**, **cost controls**, **employee choices**, **premium shares**, **treatment of annuitants**, and **financing**. Each component is examined separately, keeping all other components to the baseline specifications for that strategy. Most components have several variations, ranging from practices similar to those of the current FEHBP to those common in private sector employee health plans. Charts 3.2 through 3.7 show the variations analyzed for each component.

Each of the components is examined in four sections:

- A summary of the issues addressed in that component.
- A discussion of how that component is handled in the current program, together with a summary of the perceived problems arising from that current approach.
- A description of alternatives analyzed for each of the three strategies.
- A display of pertinent data developed for each component.

B. Baseline Costs

To anchor the framework for comparing alternatives to the current program, the FEHB Team created two "poles" for measuring the effects on costs of potential changes. These two poles represent "standards" against which Federal compensation practices are often compared. At one pole are costs of the current program, in total and as that total is shared between enrollees and the Federal Government. At the other pole are the costs of practices common to the private sector. This latter pole assumes that those practices could be sufficiently synthesized so that a hypothetical plan could be developed that represented those practices, which would then be analyzed as if that plan substituted for FEHBP. Thus, the cost of alternatives are compared to a baseline that exhibits at one end, the costs of the current program, and at the other, the cost of adopting "prevailing private sector practice."

Table 3.1 compares the cost of the current FEHBP to the cost of "typical" plans common to the private sector. These typical plans are composed of the most common provisions found in private sector plans. These typical plans are then applied to the FEHBP population, as if the plans substituted for FEHBP. The costs shown for the Federal Government and for enrollees in the table reflect weighted averages of coverage for Self Only and Family coverage both inside and outside FEHBP, as well as the weighted average of different methods of providing coverage to annuitants. This analysis does not include a "typical" plan to represent practices common to State governments because of the close similarity in costs and benefits of the typical State plans to those of the private sector.

Table 3.1 shows that the total cost of the typical private sector plan is higher than that of FEHBP. Part of this difference is attributable to the increase in the population that would be covered if the typical plans representing private sector employment were adopted for FEHBP enrollees. Because the typical plan assumes the common private sector approach of 100 percent employer-paid Self Only coverage, most of the 450,000 employees now waiving rights to FEHBP enrollment could be expected to establish their program coverage, thereby increasing the Federal payments to the program.

If the costs of plans were projected for identical populations, there would be differences in total costs because of the higher value in the typical private sector package of benefits. Note that the total enrollee share is lower for the private sector plan. This difference results from the higher percentage of total costs paid in private sector plans, after distributing all required premiums for worker, retiree, and dependent coverage across the entire group.

TABLE 3.1. Baseline Cost of Current FEHBP Compared to Costs of a "Typical" Private Sector Plan[a]
($ in billions)

	Current FEHBP	"Typical" private sector
Total program cost	$11.60	$14.50
Enrollee share	$3.41	$1.85
Government share	$8.19	$12.65
Percent share of costs:		
Enrollee share	29.4%	12.8%
Government share	70.6%	87.2%
Effects on enrollees:		
Number of enrollees (millions)	4.01	4.46
Average premium	$850	$415

[a] Costs as if plans representing "typical" practices in private employment were adopted for a population representative of the population eligible for FEHBP. Because the "typical" private sector plan assumes 100 percent employer paid Self Only coverage, about 450,000 enrollees would become covered who do not now enroll.

Source: FEHBP Model.

II. ANALYSIS OF DESIGN ALTERNATIVES

This section examines the issues addressed by the various approaches analyzed for the three illustrative strategies.

A. Benefit Design

Health insurance is primarily a system of payment for all or a portion of the cost of medical services incurred by the insured individuals. This financial protection involves the specification of the services covered and the degree to which those services will be paid. Two different benefit designs could have the same costs.

In the private sector, some health insurance plans are primarily insurance against unforseen catastrophe. These plans pay claims only after the covered individual's expenses reach limits established by the plan. Other plans provide comprehensive coverage, treating most services provided as justifiable claims for payments. Most private sector plans now generally provide fairly complete protection for expensive but rarely needed services, and lesser payments for common medical events like simple infections or routine examinations. Most plans require participants to pay some of the costs for covered services.

There are five categories of health insurance benefit design features, defined as follows:

1. *Covered services and excluded services.* Medical services for which the plan will pay all (or part) of the charges, versus those for which the plan pays nothing.

2. *Enrollee cost sharing,* including:

    -- *Deductibles.* Costs enrollees must pay for covered services before the plan begins to pick up its share.

    -- *Coinsurance.* The share of the allowable charges for covered services the enrollee must pay after the plan deductible is met.

    -- *Copayments.* A specific dollar amount per service enrollees must pay for certain services.

3. *Limits on allowable charges.* Limits on the charges for specific services to which the plan will apply its coinsurance share.

4. *Catastrophic protection.* Limitation of enrollee payments for deductibles, coinsurance and copayments for covered services when extraordinary medical expenses are incurred.

5. *Plan maximums.* Limits on total plan payments to an enrollee.

The first feature, covered services, is the only one that pertains to the actual provision of health services; the others pertain to how the costs of covered services are divided between the plan and the enrollees.

Health maintenance organizations (HMOs) are structured to provide more complete insurance coverage in return for restrictions on the choice of service providers. HMOs presume that these controls on the relationship between providers and plan participants can yield efficiencies in the delivery of services that will result in better insurance protection.

1. Current FEHBP Practice

The Office of Personnel Management (OPM) places restrictions on the degree to which plans can change their benefits from year to year, and requests certain changes each year that it wishes to see incorporated into the plans. OPM also requires that plans have certain features, and, under the law, forbids certain others. The agency does not try to modify the basic structure of plans, however.

2. Perceived Problems of Current Practice

In the private sector, considerable variation exists in the coverage provided by employer health insurance plans. FEHBP plans differ to a lesser degree, partly because of the restrictions imposed on them by OPM, but also because the opportunity for adverse selection makes plans wary of offering benefits that could attract enrollees seeking those benefits. Seen in the best light, a diverse array of benefit packages permits shrewd plan shoppers to obtain the best possible value in health benefits for themselves and their dependents. However, four factors mitigate potential advantages for most enrollees, as they consider various options:

- Because of risk segmentation, a plan's price to a potential enrollee may not indicate the value of the plan's benefits.

The premiums for a plan are significantly affected by the population enrolled in the plan. Low-risk individuals moving from one plan to another cause higher costs for the higher-risk population remaining in the plan that they left. Conversely, if individuals move to a plan to take advantage of a particular benefit, that choice passes costs on to the plan offering the benefit and to the group whose premiums help finance that benefit package.

To the extent that risk segmentation has occurred in FEHBP, premiums for individual options vary from what they would be if the plan covered a cross-section of FEHBP enrollees. The FEHB Team found that the benefit values in FEHBP options differed by 41 percent; whereas, the total premiums varied by 246 percent.

- In response to risk segmentation, plan officials market plans that appeal to low-risk enrollees and discourage high-risk enrollees.

Because FEHBP is a market in which individuals select among different health insurance options, plans have an incentive to offer benefit packages that appeal to a population that will be relatively low users of health services. If successful, plan costs will fall, and, in subsequent years, the plan will be able to offer a benefit package at a lower premium, thereby attracting more people and increasing the percentage of FEHBP enrollees that select that plan.

The same incentive that leads a plan to market to lower-risk enrollees discourages them from offering benefits that might appeal to higher-risk enrollees. Thus, FEHBP plans have reason to avoid coverage for benefits that might be warranted in a plan providing comprehensive coverage, such as certain mental health benefits, prescription drugs, organ transplants, or other procedures that could cause high-cost enrollees to join that plan.

- **FEHBP benefit packages are complex and difficult to understand.**

Review of FEHBP plans shows that there are not many extreme differences in the design features of fee-for-service (FFS) plans, but a systematic approach to comparing services and covered costs is necessary to understand the differences that do exist. Because they are prepared by different organizations, plan brochures exhibit differences in terminology and structure that serve to further confuse the reader. HMOs also do not differ substantially among themselves in the benefits offered. Although there are some difference among HMOs, a more important factor is the location of facilities and the choice of providers serving the enrollees of each particular HMO.

OPM has attempted to lessen this confusion by largely standardizing the presentation of plan benefit packages. Each open season, every eligible enrollee has access to plan brochures describing the offerings for each plan, although the ease with which these brochures can be obtained varies widely among agencies and regions of the country. FFS plans provide brochures of 24 pages, HMOs of 12 pages; both the length and format for presentation are largely controlled by the agency. Nevertheless, these brochures cannot be expected to provide enrollees adequate information upon which to base an informed choice, especially if they lack the time, inclination, or ability to discern sometimes subtle differences, many of which are technical in nature.

- Some plans contain risks that may go unrecognized.

Some advantages plans offer through lower premiums are really insurance risks in disguise. For the unfortunate few for whom the risk becomes manifest, their financial exposure is revealed at a time when they can ill afford it. Most plans pay all or a percentage of hospital and/or physicians' charges according to a determination of "reasonable and customary" (R&C) charges. Because these R&C limits vary, it is difficult to determine the actual costs until after the plan makes its payment. Others pay flat amounts for services according to a schedule. This payment schedule results in differing percentages of coverage for participants because charges vary considerably from one locality to another. A scheduled allowance (SA) that might pay a relatively high percentage in a low cost rural area will pay a much smaller fraction of total charges in an urban area where provider charges are much higher.

Furthermore, plan participants often believe that an "out-of-pocket maximum" or "catastrophic limit" prevents financial exposure from exceeding reasonably manageable amounts. Yet, many expenses that might be incurred do not count toward these limits. For example, prescription drugs, certain physician payments, or mental health benefits may be specifically excluded from coverage. Thus, for certain medical episodes, the participant can be left with thousands of dollars of obligations after all plan insurance has been applied to the total incurred charges for that event.

B. Cost Control Measures

FEHBP has not been spared the rise in the cost of health insurance throughout the economy. FEHBP total premiums have increased by an average of 12 percent annually from 1980 through 1988, compared to the average 14 percent rise incurred by private sector plans during the same period.

- Increases in the cost of health care reflect both general increases in prices, and increases in the cost of medical services.

Increases in health insurance premiums reflect not only general increases in prices in the economy, but also increases specific to the cost of health care. Premiums are the sum of all covered charges for medical services provided to a group, minus the sum of all cost sharing (deductibles, coinsurance, and copayments), plus overhead and administrative expenses, divided by the number of enrollees in the group. Thus, to the extent the quantity and intensity of services provided to a group increase, and/or the covered charges for those services increase, then premiums rise accordingly.

There are several reasons for increases in services and charges. Generally, the most important reasons are also the least controversial:

-- Increases in the average age of the group.

-- Expensive innovations in the treatment of medical conditions.

-- Expansion in the availability of extraordinary procedures.

As individuals age, the probability increases that they will become high users of medical services. Thus, as a population ages, there is a greater demand for treatment, especially for the acute or chronic conditions more frequently occurring among aged people. Since the beginning of the century, the population 65 and older has grown at a rate nearly double the rate of growth for the entire population. The population over age 85 has grown even faster. These rates of growth will continue and even accelerate as the "baby-boom" generation enters old age.

Much of this increase in the aged population is attributable to medical advances, which have reduced mortality rates for all ages but especially for the diseases of old age. These conditions are often expensive to treat. In many cases, what once was an acute condition leading rapidly to death can now be stabilized with continued treatment; though chronic, the disease becomes manageable, the person lives longer, but in a state of health that increases the probability of developing other conditions requiring treatment. Such medical advances create upward pressure on the volume and intensity of services used and the corresponding charges for those services.

To a large extent, this improvement in the Nation's health care has been made possible with financing from an extensive system of public and private health insurance, which made payment for services dependable and thus investment in both medical technology and expansion of services economically attractive. Medical service providers could become less sensitive to marketplace competition for consumer dollars as group financing buffered the upward climb of charges. In large part, providers of services were freed from considering whether their charges would be paid.

Yet, simultaneously with financing improvements in technology and availability, medical insurance expanded opportunities for consumers and providers to use services, sometimes more than necessary. Some financial arrangements among providers of different services create at least the appearance of an incentive for them to be exhaustive in the use of services for certain medical episodes. Furthermore, the rise in awards for malpractice is a disincentive for providers to limit services, and sometimes has led to more extensive (and expensive) testing and procedures even when expectations for the success of treatments are low. Finally, consumers are more accustomed to using medical services, which can also increase their willingness to undergo testing and treatment under circumstances they might have previously ignored, especially if the expense of those services is not directly or immediately appreciated.

- As health care costs have risen, employers have sought to restrain the resulting growth in health plan premiums.

Some savings are achieved by developing more efficient administrative procedures, or by self insuring, thereby avoiding both insurance vendor profits and State premium taxes. Generally, however, reducing health insurance costs requires reducing the amount of services or the charges imposed for services.

Employers have introduced methods by which the participants are required to share in the costs incurred beyond the employee premiums. Several of these strategies have been incorporated by FEHBP plans. Some of these cost-saving efforts have been undertaken by the plans themselves, while others have been required by OPM in an effort to reduce both total and Federal costs.

- One way in which employers have been able to control costs is by encouraging or requiring enrollees to participate in HMOs and PPOs.

HMOs control the participant's access to covered services by specifying the providers whose charges will be paid and by entering into contractual relationships with providers. These contracts vary from one type of plan to another and among the various kinds of providers, but basically the financial success of the arrangement depends on the HMO meeting its budget by establishing provider payments in advance, which in turn is a financial incentive for them to limit services and charges to the expected levels upon which the contracts with providers were based.

If HMOs are more efficient, these efficiencies are obtained to some extent by consolidation, into one administrative function, of certain overhead expenses that might otherwise be borne by individual providers. HMOs, especially those that own and operate facilities staffed by salaried providers, are very sensitive to economies of scale. Once overhead expenses are met, each subsequent group of participants (adequately rated for differences in demographic characteristics that could affect use) can be served at a smaller unit cost.

Savings also occur because HMOs exert greater control over service charges and reduce the use of nonessential services. It is sometimes claimed that HMOs are less costly because they provide care that can prevent the onset of certain conditions requiring treatment and because the health maintenance approach makes early detection and treatment more effective.

1. *Current FEHBP Practice*

In 1981, OPM required FEHBP plans to save money and suggested that they do so by introducing cost-sharing provisions, primarily deductibles and coinsurance. These cost-shifting provisions yielded budget savings by passing on to enrolled employees and annuitants a portion of expenses that would otherwise have been borne by the Federal Government. In addition, coinsurance and deductibles were expected to reduce use of services.

OPM has continued to encourage FEHBP plans to adopt cost control techniques common in private sector plans. While a few plans have incorporated some of these techniques, utilization controls (case management, preadmission certification, second surgical opinions, incentive to use outpatient surgery, alternative services) are not found in all FEHBP plans. Experience from the private sector suggests that these controls can save money, although considerable doubt exists that they can reduce costs substantially. Nevertheless, it is generally agreed that these practices could help to control costs if rigorously applied to the entire covered population, which is not now done.

2. *Perceived Problems with Current Practice*

Analysts of FEHBP argue that the system does not take full advantage of cost control mechanisms that could save considerable sums.

- Cost control techniques are not uniform in FEHBP plans, in part because some plan administrators think that adopting them will drive off enrollees.

FEHBP plans remain financially stable only if they are able to attract and retain sufficient numbers of participants whose expenses are below the annual premium. Because attempts to restrict use are perceived by participants to be intrusions into their relationships with providers, they are generally unpopular features in plans. In FEHBP, with its wide array of choices and annual open season, any annoyance with features to control use could cause enrollees to leave the plan, or so many plan administrators apparently reason.

Thus, some plan administrators argue that unilaterally adopting restraints on use to keep costs down could actually damage a plan's financial stability. This seeming anomaly would result if cost controls enable a plan to reduce premiums and attract enrollment, but subsequently cause healthy people who resent the controls to depart from the plan.

- The enormous potential consumer power of FEHBP enrollees is not being used to gain discounts.

Group health plans have often been able to show cost savings by entering into agreements with medical service providers. In return for encouraging participants to use the favored providers, those providers grant a discount to the plan on the charges for the services. Indeed, many systems of health insurance (PPOs, HMOs) depend on one variation or another of these arrangements in order to compete with plans assuring greater freedom to participants in the selection of providers. Such plans return these savings to the participants in lower premiums or more extensive coverage.

The Federal Government, through FEHBP, is the largest purchaser of medical services in the country. It is conceivable that discounts and other advantages could flow to FEHBP if the program could negotiate fees as a group. In the present arrangement, plans usually do not exercise sufficient consumer power to realize possible discounts.

C. Choices

Choice among a variety of plans with different benefits and premiums is potentially an important part of employee or retiree financial planning. It also serves as the theoretical foundation for the view that consumer choice will lead to the most comprehensive array of services, within a competitive market that will hold costs down. In FEHBP, there are three levels of choice:

- Between FFS plans and HMOs;
- between Self Only and Family coverage, where appropriate; and
- among different FFS plans that offer different benefits or premium amounts, or among different HMOs with varying benefits and different locations and staffing.

In the private sector, employees are sometimes offered incentives such as broader coverage or lower premiums if they choose to enroll in an HMO or PPO. Employers that offer a choice between FFS plans and HMOs generally offer that choice annually. If the employer requires the employee to pay part of the plan premiums, the amount often varies depending on the number of dependents covered. Employees can usually purchase additional coverage for dependents, often with considerable subsidy from the employer. Choice among

FFS plans is generally not permitted, except in plans in which employees are given different levels of benefits as part of a flexible benefit or "cafeteria" plan.

1. *Current FEHBP Practice*

Choice has been a feature of FEHBP since its first year of operation. To a large degree, the FFS plans and HMOs have the freedom to design benefits and determine access to providers to compete for employee participation. In some respects, the design and range of choice in FEHBP creates problems.

In 1989, FEHBP offers a total of over 450 FFS and HMO options. However, during the 1988 open season, which preceded the beginning of the "contract" year, each Federal employee and annuitant was eligible for only a fraction of these plans. Most of the plans are HMOs that can be selected only by enrollees located in their service areas.

The choices open to Federal enrollees are much greater in number than in the private sector, even for employers who offer a range of FFS options. Each enrollee could choose among the 21 FFS plans open to all enrollees. Employees in specific organizations or who worked in specific areas could choose one or two other options available only to them. The number of HMOs ranged from zero in some areas to 15 or more in areas with many HMOs, such as urban California.

2. *Perceived Problems with Current Practice*

Group insurance generally implies that choice does not occur, it being a principle of group insurance that the burdens are shared by all regardless of the costs incurred by each. Because FEHBP permits participants to choose among different plans, the total participant population is not insured as a single group. Insurance is deployed through many plans, each of which insures its population separately.

Several problems have arisen in FEHBP as a result of this unusual opportunity to choose.

- Choice has caused the FEHBP population to fragment, concentrating similar risks in some plans.

Premiums for health insurance plans are the cost of benefits plus overhead and administration for a covered group. The characteristics of the covered group are a significant factor in the total amount of benefits that a group uses. Some plans incorporate benefits that appeal to younger workers, and drop benefits of interest to older workers and retirees. The choices of FEHBP participants have led to a concentration of groups with similar health risks in similar plans.

- This risk segmentation has led to diverging premiums for plans of similar value.

The premiums of many FEHBP plans are more affected by the population they cover than by differences in their benefit packages. If the entire FEHBP population were insured under one plan, then all participants could have the same premiums, the only variation being one of Self Only or Family coverage. Because of the congregation of lower risks in some plans and higher risks in others, premiums under the current program vary considerably from plan to plan.

The FEHB Team developed a methodology for evaluating the various factors affecting the cost of a health plan. One technique permits comparing the value of different plans against a common standard. The team found that the 9 most popular FEHBP plans differed by no more than 35 percent in the value of their benefit packages from lowest to highest, but differed by 246 percent from lowest to highest in actual total premiums.

- Some options have experienced spiralling cost increases.

The rate-setting mechanism results in differences in the total premium and the enrollee premium that are often much greater than the actuarial value of the benefit differences. The difference in cost occurs because of adverse selection associated with the FEHBP method of setting rates. This problem does not occur in the private sector for two reasons. First, with self insurance, plans are not financially independent, so rates need not be adjusted to reflect actual plan experience. Second, since enrollees are not charged for the adverse selection of others as they are in FEHBP, they will not be pushed toward risk segmentation in their plan elections.

The shifting of costs so that an option experiences spiralling increases can be seen by comparing Blue Cross (BC) High Option with BC Standard Option. In 1989, the benefits for the two options have almost the same actuarial value. If there were no adverse selection leading to risk concentrations, the two options would cost about the same. However, over the years the High Option has become the choice of those with the highest expenses, and the Standard Option has attracted an average cross-section of risks. From 1987 to 1989, with each open season, more than a third of the enrollees left the High Option, with most of those transferring to the Standard Option. The premiums of the Standard Option increased by 67 percent, while those of the High Option increased by 137 percent.

- Considerable confusion exists about the choices available.

There is little difference in the major benefit coverage among most FEHBP FFS plans. As a result, enrollees are faced with what is only apparently a wide range of choice. Confusion about what are often minor differences is worsened by the lack of clear and complete information on the choices.

D. Premium Shares

The "proper share" of health insurance premiums that should be paid by individual enrollees and their Federal employer is a matter to be determined by balancing the need to compete for talent against restrictions on Federal budget outlays. An exception is the U.S. Postal Service, whose employees collectively bargain their health insurance premiums as part of their overall compensation package.

In the private sector, most employer-sponsored plans do not require premiums for employee coverage, although most plans require payments to defray part of the costs of dependent coverage. However, private sector employers are able to deduct premiums, as a business expense, from corporate income taxes. If employees themselves paid these premiums, they would have to do so from their net, after-tax income (as do Federal employees). Thus employees may gain from having health insurance costs paid for them, even if those payments cause a corresponding reduction in wages that they would otherwise be paid.

1. *Current FEHBP Practice*

Federal workers and annuitants enrolled in FEHBP help finance the program. The enrollees' (after-tax) contributions equal the total premium less the Government's share. A two-part formula, specified in law and commonly known as the "Big Six" formula, sets the Government's share separately for Self Only and Family coverage. First, the Government contribution is a flat-dollar amount equal to 60 percent of the average premiums for the high-option plans offered by six selected carriers. Second, the contribution is limited to no more than 75 percent of the total premium for a particular option. The two limits on agency contributions for postal workers, determined through collective bargaining, are a flat-dollar amount equal to 75 percent of the Big Six formula, and no more than 93.75 percent of any option's premium.

2. *Perceived Problems with Current Practice*

The Government's premium-sharing formula contributes to risk selection, which causes the highest premiums to be borne by those with the highest medical service use, and also causes the average Federal share of program payments to rise. Furthermore, even though they may choose relatively inexpensive plans, low-income enrollees spend higher proportions of their income for health insurance than do enrollees with higher incomes in that the premium-sharing formula is not progressive with income.

- The current method for determining premiums, and the respective share paid by the Government and each enrollee, contributes to risk segmentation.

The Government contribution, within certain limits, is a dollar amount equal to 60 percent of the unweighted average of six plans in the program.

This formula is known as the "Big Six". The six are the Aetna and BC High Options; the two most popular enrollee organization plans; and the two most popular HMOs.

This dollar amount represents a higher proportion of total plan costs for some plans compared to others. Because these differences in plan premiums *reflect differences in the population covered by the plan more than any* differences in benefit values, the flat dollar amount of the Federal payment means that enrollees are subject to the costs of risk segmentation, unless they avoid those plans. Eventually, enrollees tend to be rationally drawn to lower-cost plans.

- The Big Six formula, operating in a context of severe risk segmentation, drives up the Federal share of program cost.

There is a widely held view that the existence of choice in FEHBP has significantly increased the program cost. While adverse selection and the rate-setting method do increase costs for individual plans, costs are reduced for others. Choice does not significantly affect the total cost of FEHBP, but choice does cause the Government share of the total program cost to increase, because of the method for determining the Federal share of the premium.

The adverse selection by high risk enrollees that has driven up the costs of Aetna and BC High Option plans has increased the Government contribution and its proportion of the total premium. Because these two plans are included in the formula for determining the flat-dollar Federal contribution, their increasing costs from risk segmentation have a disproportionate effect on Federal payments, causing them to rise faster than average premiums. In 1989, the average Federal contribution in FEHBP is 71 percent, up from 60 percent in 1982.

- Inequities have arisen in the distribution of costs.

The average FEHBP participant now pays less than 30 percent of the total cost of plan premiums. However, those relatively few enrollees who have elected to remain in the High Options of Aetna and BC pay nearly 65 percent. Because these enrollees are relatively higher users of medical services, this disparity in costs of health insurance would appear to be counter to a group insurance philosophy that the highest costs should be spread across the widest population possible.

Because Federal payments are flat dollar amounts, individuals receive the same general premium subsidy from the Government, regardless of any differences in income level. Thus, premiums that employees pay represent different proportions of total income, with lower-income workers paying a higher percentage of their incomes for health insurance.

The premiums FEHBP enrollees pay also tend to vary by their age and income, as a result of the segmentation pattern. Among active workers (including postal workers), the average premium of the plans in which workers are enrolled tends to increase with age, even after controlling for workers' pay levels. Also, within each age group, higher-paid Federal workers, on average, choose plans with premiums that are higher than the plans that lower-paid workers choose. However, FEHBP premiums, as a percent of enrollee pay, are higher on average for lower-paid Federal workers, even though these workers tend to be enrolled in cheaper plans.

E. Annuitants

As older people, annuitants on average use more medical services than active workers. Thus, FEHBP is an important element in the retirement rights earned through Federal employment. Most retirees age 65 and over are also entitled to Medicare, which many Federal retirees believe should result in a corresponding reduction in their FEHBP coverage and costs to take into account any overlaps in coverage that result from dual eligibility.

1. Current FEHBP Practice

Annuitants enroll in FEHBP under the same coverage options (i.e., for Self Only or Family coverage), have the same annual open season, pay the same premiums, and except for those with Medicare, receive the same benefits as active workers. They are included in the same risk pools as are all participants in the various FEHBP plans. To enroll, an annuitant must have participated in FEHBP during the 5 consecutive years before retirement. Annuitants who cancel their FEHBP coverage cannot later re-enroll in the program. About 500,000 annuitants do not participate in FEHBP.

Except for differences in the way supplemental premiums for Medicare catastrophic insurance are calculated for Federal and other governmental annuitants, FEHBP annuitants entitled to Medicare are treated the same under Medicare as are all others who are entitled to Medicare. However, because most medical services are covered by both Medicare and FEHBP, these programs coordinate their benefit payments to ensure that the enrollee is not paid twice for the same service.

By law, Medicare is the "primary payer" of covered bills for annuitants who are entitled to that program unless they are employed. This means that Medicare pays for most hospital expenses and/or physician services. OPM requires that each plan participating in FEHBP waive its hospital and/or medical deductibles and coinsurance for enrollees entitled to Medicare. Thus, annuitants with both Medicare and FEHBP have virtually 100 percent of their hospital and doctor bills covered.

2. Perceived Problems with Current Practice

The number of retirees enrolled in FEHBP is increasing, and this causes two kinds of problems. First, to the extent that retirees congregate in certain plans, they will cause those plans to have higher costs because of their higher medical service use, until they reach the age of 65 and Medicare begins to pay a large portion of their claims. Second, the existence of Medicare as primary payer causes plan costs for enrollees covered by Medicare to decline, and many of these annuitants argue that their premiums should decline accordingly.

- Annuitants cause plan costs to rise.

Because annuitants as a group are high users of medical care, those without Medicare increase the overall cost of the FEHBP plans. From this perspective, FEHBP is a good deal for them since healthier younger workers and older annuitants with Medicare can be said to subsidize their care. On the other hand, the data show that a high proportion of annuitants without Medicare (and, contrary to logic, a fair proportion of those with Medicare) enroll in high-cost plans that do not provide protection commensurate with the level of the premiums they must pay and where costs continue to rise as healthier employees leave to join cheaper plans.

- Duplicate coverage by Medicare raises questions about equitable treatment.

Because it pays for most of their medical bills, Medicare reduces the cost of annuitants' participation in FEHBP. As a result, a persistent complaint made by FEHBP enrollees with Medicare is that they are buying coverage under FEHBP that duplicates Medicare coverage and that their FEHBP premiums are subsidizing others (workers and annuitants without Medicare) in FEHBP. The issue is intensified due to the recent addition of catastrophic coverage under Medicare, which largely duplicates benefits available under FEHBP. It is said by some that annuitants with Medicare get a "bad deal" from FEHBP, that their premiums are too high for the benefits they receive.

The data show that, per enrollee, annuitants with Medicare have the lowest cost to FEHBP, and thus could be said to receive less value from the Federal payments to FEHBP than other participants. The average enrollee premium represents 29 percent of the cost of benefits. Using these rough estimates, the average enrollee share falls from 29 percent to 18 percent for annuitants not covered by Medicare, and rises to 38 percent for annuitants covered by Medicare. The average share for workers is 34 percent.

However, the value of the FEHBP benefits they do receive are greater than their premiums, so they get at least their "moneysworth" from FEHBP. Furthermore, FEHBP enrollees covered by Medicare receive $3.10 per month (in rebated FEHBP premiums in 1989) to reflect savings to FEHBP of the new catastrophic coverage of hospital services (Medicare Part A).

The impact of the new premiums for Medicare catastrophic insurance is not uniform--not everyone will pay them, and for those who do, the amounts will vary widely. One is a surtax on income tax liabilities of people who are eligible for Part A of Medicare or who would be eligible if they applied. This amounts to $22.50 per $150 of tax liability in 1989. The other is an add-on to the monthly flat rate premium paid by Part B enrollees. FEHBP enrollees with little or no income tax liabilities will pay nothing for the broadened Part A coverage. Those who are not enrolled in Part B of Medicare will not receive or pay for the new Part B benefits. In 1989, those who are enrolled in Part B will pay a $4.00 monthly add-on to the regular Part B premium.

- FEHBP coverage for annuitants compares favorably to coverage for retirees in the private sector.

In the private sector, about 24 percent of large and medium employers do *not* provide medical coverage to retirees. Of those that do, 90 percent extend coverage past age 65. About half of the employers who continue group coverage for retirees pay the full cost, but 15 percent pay nothing and require the retiree to foot the bill. Private sector annuitants whose employers provide them with broad coverage after age 65 also are critical of the new Medicare catastrophic coverage, asserting that the additional catastrophic premiums give them little or no additional coverage.

In the aggregate, the impact on Federal retirees of the introduction of the new catastrophic benefits under Medicare does not appear to be significantly different from that on retirees in the private sector. To the extent private employers do not continue the so-called "maintenance of effort" practices beyond the period required in the law (i.e., after 1990), Federal retirees would be in a slightly advantageous position since there is no expiration in the comparable "rebate" requirement for FEHBP plans.

F. Financing

In a private market for health insurance, vendors of health insurance plans establish a premium for an insured group by considering the factors that would affect that group's use and cost of covered medical services and the insurer's costs and profit requirements for providing the insurance. The insurer makes a profit if the premiums are sufficient to cover those costs. In FEHBP, this market concept is modified by Federal involvement. OPM is involved in the design and premium rating of benefit packages. Plans are required to maintain reserves, modify rates to reflect past gains and losses, and account for their administrative costs. Profits are set by law. Thus, in an important sense, the Federal Government operates as if self insured but maintains some financial operations as if it were not.

1. *Current FEHBP Practice*

Financing FEHBP requires the establishment of annual premium rates that are sufficient to cover the payment of claims, profits, administrative expenses, plus additional amounts to maintain required reserve levels. FFS plans, which cover 70 percent of all FEHBP participants, must base their premiums on their claims-cost experience. End-of-the-year losses are rolled forward and recouped in subsequent years' premiums. Most FEHBP HMOs are community rated, which means that their premiums are based on the experience of Federal and nonfederal participants alike.

Most of the individual FFS plan sponsors are reinsured by one or another of the Nation's larger insurance companies. The reinsuring company also places requirements on individual plans. If a sponsor ceases to participate in FEHBP after incurring financial losses, the reinsuring company must absorb the loss. Some of the smaller HMOs could also become unstable if their outgo exceeds income for a prolonged time.

2. *Perceived Problems with Current Practice*

The method for establishing premiums in FEHBP assures that plans that have accumulated high-risk enrollees will continue to have high premiums, thereby encouraging migration to lower-cost options. Most plans can respond to this spiral because they are not forced to offer a high and a standard option. Thus, they can facilitate migration from their high option plans to the standard option, eventually discontinuing the offering of the high option plan. This is not true for Aetna and BC, however, because the law requires that they provide two levels of benefits.

- Maintaining reserves adds to premium costs.

Under the current rate-setting procedures, FEHBP premiums include a yearly reserve cushion equal to 3 percent of total premiums. But there is no clear idea of how large total FEHBP reserves need be. Because the need to draw on reserves varies each year and among plans, some carriers have significant reserve levels while others may be underfunded. The law does not address this variation, or even recognize the relationship between accumulated reserves from prior-year surpluses and the forthcoming reserve cushion. Those relationships are controlled by OPM's guidelines that, in the recent past, have changed from one year to the next.

- FFS plans operate at limited risk.

Conceptually, any FEHBP plan might terminate its contract in a deficit position. For instance, an FFS option could face financial difficulty and be unable to recoup its prior-year FEHBP losses and, at the same time, remain competitive with other plans' benefit options. If the plan ceased to participate in FEHBP, then the insurance company underwriting the plan could experience some loss that it could not regain through subsequent FEHBP premiums. It could be presumed, however, that those insurers would pass losses on to the broader pool of insured clients with whom they maintain ongoing contracts in the larger health insurance market.

As discussed above, however, plans other than Aetna and BC could theoretically avoid such a problem without too much difficulty. From this perspective, the Government already self insures (nearly all) FEHBP's FFS plans. Formalizing this de facto arrangement would eliminate the basis for "risk charges." The FFS sponsors collect these payments even though they are essentially claims processors.

- A new letter-of-credit arrangement will help reduce the impact of reserves on program financial requirements.

Until this year, FFS plans maintained and invested certain reserves on behalf of FEHBP. Increasing reserve levels, with no apparent threat to program insolvency, led to questioning the necessity of these high reserve levels. OPM addressed this issue by establishing a letter-of-credit (LOC) arrangement. Under this arrangement, these reserves have become Federal assets, with protection for individual plans based on the financial security implicit in the operations of the Federal Government.

The FEHBP's cash flow should improve because some program financing previously held outside the program and counted as program expenditures will now be accounted for internally. Nevertheless, it is unclear why it is necessary to maintain funds on a plan-by-plan basis rather than in a single reserve account, especially when it has not been established to what extent reserve levels are actually needed.

III. STRATEGIES FOR REFORM

In this section, a methodology for analyzing alternative means of reforming FEHBP is demonstrated. That analytic framework examines FEHBP issues in the context of three general strategies, with variations in the specifics of those strategies compared. The strategies are not recommendations or proposals. They are illustrations of the methodology and a way for FEHBP issues to be examined in a context of perceived problems and possible solutions.

Each strategy is made up of six components, and each component includes several variations. Three general strategies are examined:

- A package of changes to the current program.
- A new program, restructured to provide multiple choices within a controlled environment.
- A new program, structured to resemble the plans typical of large firms.

Chart 3.1 shows the baseline approaches assumed for the six components for each of the three strategies. Charts 3.2 through 3.7 show the variations in approaches for each component in the three strategies. In the discussion of each component, the particular variation(s) (baseline provisions) selected for inclusion in what might be called the "baseline" plan for that strategy are designated by an asterisk *.

CHART 3.1. Baseline Provisions of Illustrative Strategies

Provision	Strategy 1	Strategy 2	Strategy 3
Benefit design	Establish minimum benefits standards	Number of different core benefit designs--one Number of different types of supplements--three	One FFS plan, specified design.
Cost control	Establish minimum standards	Specify controls and monitor their applications	Direct controls on on providers
Employee choices	Permit plans to eliminate options Limit union plans to members	FFS core option with three supplements	One FFS plan
	Number of HMOs--unlimited	Number of HMOs--unlimited	Number of HMOs--limited
Premium shares	Gov't pay 60% of weighted average of all plans	Gov't pays 100% of core for employee and 75% for dependents; part of supplement	Gov't pays 100% for employee and 75% for dependents
Treatment of annuitants	Separate medigap option with equivalent of current benefits Gov't pays 75% of premiums for enrollees and dependents	Separate medigap option with equivalent of current benefits Gov't pays 75% of premiums for enrollees and dependents	Separate medigap option with equivalent of current benefits Gov't pays 75% of premiums for enrollees and dependents
Financing	Self insured with current reserve and rating structure	Self insured with reserves Exempt FEHB from State premium taxes	Self insured without reserves Exempt FEHB from State premium taxes

A. Strategy 1: A Package of Changes to the Current Program

Strategy 1 presumes that the perceived problems of the current program could be addressed without completely reshaping it. To be considered successful, this package of changes would probably need to assure that the current risk segmentation does not cause plans to become unstable. Enrollees could be spared the high premiums caused by risk segmentation, but the solution would require redistributing the current costs among FEHBP participants; otherwise Federal costs would rise. Enrollees could also be protected from certain kinds of risks not easily recognized, and OPM could be required to evaluate and publicize actual differences among plans more aggressively. Money could be saved if cost controls were widely employed. A separate plan could be developed for annuitants covered by Medicare.

1. *Benefit Design*

Several approaches are possible to these issues in the design of FEHBP benefit packages that do not require total restructuring of the program. These approaches all would limit FEHBP plans' current freedom to specify covered benefits. As a result of this greater restriction on the design of plans, participants would be trading greater certainty in coverage for lessened choice in plan variability, a potential disadvantage to some participants who have benefited from the current approach.

a. Require the same benefits in all plans. The most certain means for addressing issues arising from the variation in benefit packages among FEHBP plans is to specify benefits that must be offered by plans participating in the program. If this approach were adopted, participants would have no incentive to switch plans in order to attain coverage advantages, and the dynamic leading to risk segmentation would be greatly reduced. Confusion about insurance protection would be lessened, and participants could be better informed as to their actual financial exposure.

Numerous issues would need to be resolved were all FEHBP plans required to offer the same benefits. First of all, the generosity of a specific standard package would need to be established. The existing array of benefit packages would need to be modified, which would cause premiums to change, in many cases quite dramatically. If the standardized benefit package were to be at least as generous as the "typical" FEHBP plan, premium costs would increase for many participants. Also, to establish a specific benefit package means that reimbursement would be provided for some services, but not for others. Drawing these necessary insurance distinctions in a political environment could be difficult.

Furthermore, current FEHBP plans operate with some degree of market flexibility that may be a necessary condition to their continued participation. If plans ceased to participate, the redistribution of the FEHBP population would also affect projections of insurance liabilities and premiums of individual plans.

Finally, it could be argued that the current multiple choice design is an essential characteristic of the program, so that if that characteristic were removed, FEHBP should be modified in other significant ways as well. While it may be pertinent to conjecture that perceived problems in FEHBP would not have arisen had a standardized benefit package been required from the beginning, the fact of current risk segmentation makes standardizing the benefit packages possible only if other major modifications in the program are made simultaneously.

b. Establish a core package of benefits. Many of the problems that would arise from establishing a standard package of benefits would be alleviated if a core package were established and plans were permitted to offer additional benefits beyond the required core. Each plan could be required to provide the same deductibles, coinsurance, and out-of-pocket maximum, thereby assuring participants that the major insurance components did not differ from plan to plan. This approach would lessen confusion during open seasons, and remove much uncertainty about the degree of financial exposure of participants.

The problem of determining the actual core itself, while less burdensome than creating a complete standard benefit package, would still be difficult. Depending on the degree of freedom granted to plans in the offering of additional benefits, complexity in plan benefits could be expected to continue. Even if the package of additional benefits were required to be "actuarially equivalent" from one plan to another, participants would have little basis for determining the actual desirability of one plan or another, unless they expected to use particular benefits.

The "core-benefit" approach could reduce but not eliminate the current risk segmentation. Offerings of additional benefits would cause differences from plan to plan, and participants could be expected to choose plans according to their own assessments of advantages in one plan or another. Generally, the most apparent difference among plans would be in the participant premium. Unless steps were taken to eliminate the current risk segmentation, many participants would still choose according to premium amounts, which would reflect the profile of the group more than any actual benefit value differences.

*c. *Establish minimum benefit standards.* Instead of specifying a core of benefits, legislation could establish minimum benefit standards. This approach would allow plans to compete for market shares by offering benefit packages that vary in the degree with which they emphasize particular insurance protections beyond the minimum standards. This approach is included in the overall cost projections for *strategy 1*.

Under this scenario, each plan would be required to have:

- An overall plan deductible of no more than $200 that applies to all covered expenses (including hospital and surgical).

- Plan coinsurance payments of no less than 75 percent on all covered expenses. Surgical schedules would not be allowed and plans would have to demonstrate that their R&C cover at least 90 percent of all charges.

- An annual maximum out-of-pocket limit of no more than $3,000.

- "Reasonable and necessary" hospital and physician charges would have to be covered. Each plan would be required to offer prescription drug coverage. Dental coverage would not be required.

Requiring all FEHBP plans to meet minimum standards would reduce the extent to which participants are exposed to uncertain risks. Many plans would already meet this minimum standard and could continue to operate as they do now.

While establishing a minimum standard would probably be less controversial than actually specifying the benefits that must be offered, considerable disagreement could arise as to an appropriate minimum.

Furthermore, the establishment of minimums would not address the existing segmentation of the FEHBP population into risk groups. Unless other changes were made, requiring minimum benefits would cause the premiums of some plans to increase, which in turn could alter the current concentration of risks. It is doubtful, however, that this alteration would be sufficient to stabilize enrollment in plans facing "risk spiralling," nor would it necessarily prevent new instances of risk spiralling.

If all other aspects of the program were held constant, this action would increase costs because some plans would pay more in benefits. It is assumed that the other two changes in this section would involve redesigns that, in aggregate, cost the same as the use of minimum standards.

d. Retain current practice. OPM places restrictions on benefit design changes but does not try to modify the basic structure of plans.

CHART 3.2. Alternative Provisions in Benefit Design

Strategy 1	Strategy 2	Strategy 3
a. Same benefits plans	a. Three to five options with minimum benefit specified	*a. One plan, in all specified design
b. Core package of benefits	*b. Core option with supplements	
*c. Minimum benefit standards		
d. Current practice		

* Denotes baseline provision for each strategy.

2. *Cost Control Measures*

Financial incentives to discourage utilization, i.e., coinsurance, copayments and deductibles, can be incorporated as part of the basic design of the plans' benefit structure, as was discussed in the previous section. In addition, FEHBP could be modified to incorporate other cost controls.

a. Specify control measures for all plans. FEHBP could require all plans to adopt a specific package of cost controls. These provisions could, for example, restrict the use of expensive procedures if less expensive alternatives were available. By requiring all plans to adopt these approaches, incentives for participants to move to plans without such controls would be eliminated. If an effective cost control program or package could be developed, FEHBP would, as a program, be better positioned to attain any savings that could be realized through such controls.

Plans would be monitored using a standardized reporting format that would permit the development of an FEHBP data base. Developing a data base of services utilization would permit the analysis of practice patterns, and improvements in the application of effective procedures could be expected. Nevertheless, enforcing cost controls is a difficult task that would involve a considerable increase in OPM's current administrative responsibilities for FEHBP.

The difficulty with mandatory cost controls for all plans is that there is little agreement about the success of particular approaches. Some plan administrators claim that certain purported cost control techniques do not result in savings, because the administrative costs of applying them offsets the savings. Also, there is evidence that, as certain control procedures are instituted, providers respond by increasing services. For instance, as hospital services are constrained, there is a rise in outpatient services.

In addition, requiring all plans to have the same cost control procedures may blur the distinction between FFS plans and HMOs. One important aspect of HMOs is that such arrangements usually diminish services received by plan participants by methods similar to cost controls used by FFS plans.

*b. *Establish minimum standards.* To retain consistency in this strategy, a minimum package of cost control measures could be required, to go with the minimum specified benefits of the previous section.

c. *Direct controls on providers.* The most aggressive forms of cost control involve limiting payments to providers and defining more narrowly the definition of "reasonable and necessary" services for specific medical conditions.

It is possible that FEHBP could achieve some program savings if the entire FEHBP population were to be engaged as a "bargaining" group. To achieve this objective, however, would require considerable uniformity in FEHBP plans.

Aggressive limits on payments to providers is gaining favor at the national level, as both Medicare and CHAMPUS limit hospital charges per admission directly.

The FEHBP could join these Federal efforts to constrain growth in health care costs by adopting direct controls on utilization and on providers' charges attached to services performed for FEHBP participants. It is important to appreciate, however, that these policy approaches are highly controversial, and that it may be some years before adequate information exists by which they could be properly evaluated.

In the meantime, some critics of these approaches suggest that interfering in medical practice so directly would diminish the quality of care. Others suggest that research would suffer and that expansion of needed services would be hampered. Finally, some evidence suggests that, as procedures and charges are restricted for some practices, the provider community responds by increasing the services and charges in others.

d. *Retain current practice.* OPM encourages the use of cost controls, but does not require or monitor them.

CHART 3.3. Alternative Provisions in Cost Control

Strategy 1	Strategy 2	Strategy 3
a. Specified control measures for all plans	*a. Specified control measures for all plans	a. Specified cost controls
*b. Establish minimum standards	b. Minimum standards	*b. Direct control on providers
c. Direct control on providers	c. Direct controls on providers	
d. Current practice	d. Current practice	

* Denotes baseline provision for each strategy.

3. Choice

*a. *Permit Aetna and the Blues to eliminate their high options.* The Aetna and Blues High Options have become excessively expensive because of risk segmentation. As a result, most of the enrollees in the two options are paying much more than needed for the same health care they could receive in other options. The FEHB Act requires the two plans to have two options, so a change in law would be required.

These two high options are used in determining the Government's FEHBP payment, and removing them would require a change in the formula. Furthermore, BC High Option has the most substantial mental health coverage available in FEHBP, and eliminating that option raises the issue of the extent such coverage should be available in the program.

*b. *Limit employee organization plans to members.* Most of the employee organization plans offer benefits that are very close in design and actuarial value to those of the Government-wide (BC and Aetna) plans. Because of adverse selection, premiums of the various employee organization plans are considerably smaller than premiums of BC and Aetna. If the Federal share of premiums were adjusted to reflect the impact on plans of adverse selection, and FEHBP were to become self insured, this difference would also disappear (discussed below in section 4, *Premium Shares*.

As a result, the employee organization plans would offer a choice not much different from the Blues and Aetna. Therefore, there would not be a need for employee organizations to serve nonmembers. Continuing to offer these apparent choices to all FEHBP participants would further the confusion without establishing a real choice.

Further, this change would also eliminate the associate membership fees nonmembers now must pay in order to join organization health plans. While these fees are often an important source of revenue to the employee organizations, they do not buy any insurance value.

However, restricting employee organization plans to members, coupled with the eliminating High Options of the Blues and Aetna, could result in giving most participants only the choice between Standard Options of the Blues and Aetna. To maintain a wider choice, one to three additional options could be permitted to continue, especially if they added substantially to the range of actual variety. With few or no competitive options, enrollees would have little recourse when plan administration was curt, slow, demeaning, overly complex or otherwise tending to discourage the filing of claims.

c. Limit number of health maintenance organizations. FEHBP's relationship with HMOs with fewer than 300 members would be ended unless they were the only ones in a service area. All other current HMOs would be allowed to continue. New plans would be accepted only if they added a significant new type of choice to the enrollees in the service area.

d. Continue current practice. Because the current program is thought by many to provide an important opportunity for employees and retirees to maximize the value they receive for their health insurance premiums, the current array of choices could be retained.

CHART 3.4. Alternative Provisions in Employee Choices

Strategy 1	Strategy 2	Strategy 3
*a. Elimination of High Options in Blue Cross and Aetna	*a Number of different core benefit designs--one	*a. Number of HMOs--limited
	Number of different types of supplements--three	
*b. Employee organizations plans limited to members	*b. Number of HMOs--unlimited	
c. Limited number of HMOs		
d. Current practice		

* Denotes baseline provision for each strategy.

4. *Premium Shares*

**a. The FY90 President's budget proposal (60 percent of weighted average of all plans).* This proposal was included in the FY 1990 budget submitted to the Congress by both the Reagan and Bush Administrations. The average premium establishing the Federal payments to plans would be based on the prior year's enrollment (e.g., the 1990 Government premium would be based on 1989 enrollment, because the 1990 enrollment would not be known at the time of the open season). The Postal Service would pay 75 percent of the weighted average, and the maximums would still be 75 percent for nonpostal and 93.75 percent for postal workers.

b. Development of risk adjustments in plan rates. In the current approach, plans receive the same Federal contribution for each participant. "Risk adjusters" would vary the Government share based on categories of risks. Plans would receive extra dollars to the extent their enrollees were judged to be higher-than-average risks. Risk adjusters could be based on demographic characteristics and related information, such as annuitants without Medicare coverage and the incidence of nonelective surgery.

However, while demographic characteristics are generally known for FEHBP enrollees, they are lacking for their participating dependents. In addition to a significant expansion of OPM's data collection efforts, implementing a risk-adjusted approach would require substantial changes in the current FEHBP environment. In the first year of implementation, all FFS options would offer the same standardized benefit provisions, and the premiums paid by the enrollees would not vary among options. (Enrollees selecting the Family option would continue to pay more than those who chose Self Only coverage.)

Aetna and BC have suggested a risk-adjusted approach for distributing the Government premium contributions. Advocates of this change say that it would greatly reduce the conditions that foster risk segmentation. Critics of the approach suggest that it would make a complex program even more so, with little certainty of correcting the problems.

In any event, risk adjusters either redistribute Government contributions from one plan to another, or they necessitate increasing payments to certain plans. The former approach raises all of the issues associated with redistributing burdens, including the immediate impact of higher premiums for some plan participants. The latter approach means increasing the short-term Government cost while retaining the current plan structure.

c. *Specify fixed enrollee rates for each plan with Government paying balance*. Benefit provisions and enrollee contributions, under this approach, need not be standardized. The estimated differences in benefit values among alternate plan provisions, rather than the concentration of high-risk enrollees, would determine the size of the enrollee contributions.[16]

d. *Separate rates for different family sizes*. Health insurance premiums that distinguish among couples with and without children, and take note of singles with children, are becoming more commonplace in the private sector.

e. *Continue current practice*. Because changing current Federal contribution levels could be perceived by participants as an effort to shift costs to them, pressure may exist to continue the current practice.

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[16] Using a representative sample of the FEHBP population, the Government would assign benefit values to a core benefit package and to three or four options with richer benefit provisions. Each enrollee would pay a base premium amount, as determined by the core benefit package common to all options, plus the estimated value difference between his/her selection and the core benefits.

CHART 3.5. Alternative Provisions in Split of Contribution

Strategy 1	Strategy 2	Strategy 3
*a. FY90 President's budget proposal weighted average of all plans	a. Federal payment for 100% for employee coverage and 75% for dependents for the core package, and part of supplement	a. FY90 President's budget proposal 60% of core
b. Development of risk adjusters in plan rates	b. Separate rates for different family sizes	*b. Private sector practice of full payment for employees and 75% for dependents
c. Enrollee rates with Gov't paying balance	c. Separate rates for different family sizes	c. Separate rates for different family sizes indemnity contribution
d. Separate rates for different family sizes		d. Separate rates for different family sizes
e. Current practice		

* Denotes baseline provision for each strategy.

5. *Treatment of Annuitants*

**a.* *Set up separate "medigap" options.* Each plan could be permitted to add a medigap option, or there could be one option for all Medicare enrollees. The option would have the same total benefits as the current average or "typical" FEHBP plan, but the rate would depend only on the participants in the option. The Government would pay three-fourths of the cost of the Medicare option.

b. Waive or pay the Part B Medicare penalty. Some Federal annuitants are covered by Part A of Medicare but have not elected to be covered by Part B. Annuitants without Part B would not be able to receive sufficient coverage from the separate medigap option. These annuitants could now elect Part B coverage but would have to pay Medicare's late penalty.

The offering of a separate medigap option would change the situation from when the annuitants first declined Part B. Many annuitants probably believed that the Part B coverage would not provide sufficient additional insurance to warrant its additional costs. However, under a separately-rated option, it might be advantageous to buy Part B. Therefore, it might be equitable for the Government to pay or waive the Part B penalty.

c. Retain current practice. All annuitants would have the same benefits plan, and pay the same premium, as employees. Most annuitants with Medicare would receive a greater value in benefits than they pay in premium. However, the Medicare annuitant's share of the total premium which is paid by the Government is less than for employees and much less than for nonmedicare annuitants. Medicare annuitants who stay in the highest cost plans would pay more in premiums than they would receive in benefits.

CHART 3.6. Alternative Provisions in Treatment of Annuitants

Strategy 1	Strategy 2	Strategy 3
*a. Separate medigap option in each plan	*a. Separate medigap option in each plan	*a. Separate medigap option in each plan
b. Waive or pay the Part B Medicare penalty	b. Waive or pay the Part B Medicare penalty	b. Waive or pay the Part B Medicare penalty
c. Current practice	c. Current practice	c. Current practice

* Denotes baseline provision for each strategy.

6. *Financing*

**a. Self insure with current reserve and administrative expense structure.* FEHBP is a de facto self-insurance program. As with most large employers, the primary function of the insurers is to process and pay claims. In the last analysis all claims are financed by the Government and enrollees. However, since there is at least a theoretical risk, the insurers ask for margins in the rates, and there is a complex interaction of premiums and reserves that simulates an insurance process at little advantage to the Government or the enrollee.

The current method for setting plan premiums leads directly to risk selection problems. Rates could be set to achieve equity among enrollees without considering the relative risk of each group of enrollees. The total cost of FEHBP would not change, but it would be redistributed among plans.

If self insurance were adopted, the Government could still maintain the same general reserve levels and avoid using general funds except as a temporary measure in the worst years. One advantage of self insurance is that the employer does not have to pay a premium tax in most States. This advantage might, however, prove to be a disadvantage to States receiving the taxes.

b. Self insure without reserves. This approach would eliminate the yearly 3 percent add-on, or reserve cushion, and would liquidate current reserve accumulations. This change could occur gradually, or it could provide a one-time reduction in premium increases. Current reserves total some $1.2 billion, or about 10 percent of 1989 premiums.

c. Disallow premium taxes. FEHBP plans are already exempt from State minimum benefit provisions, but they do pay State premium taxes. Self insurance would eliminate premium taxes.

CHART 3.7. Alternative Provisions in Financing

Strategy 1	Strategy 2	Strategy 3
*a. Self insured with current reserve and administrative expense structure	*a. Self insured with reserves	a. Self insured with current reserve and administrative expense structure
b. Self insured without reserves	b. Self insured without reserves	*b. Self insured without reserves
c. Disallow premium taxes and/or profits	*c. Disallow premium taxes and/or profits	*c. Disallow premium taxes and/or profits
d. Current practice		

* Denotes baseline provision for each strategy.

B. Strategy 2: A New Multiple Choice Program

Current FEHBP plans, while they sometimes differ in important respects, do exhibit considerable similarity. The package of changes to current law examined in *strategy 1* would eliminate the extremes of the variation that does exist among plans. In combination with other changes, *strategy 1* would presume that evolution would continue, but under more controlled conditions. It is reasonable to assume that remaining plan differences could be presented to employees clearly enough so that market forces would eventually consolidate populations in a few plans, especially if rate structures eliminated premium advantages now held by a segment of the workforce. If participants were subsidized equally, and plan rates were developed against a standard Federal employee population, participants could be charged the premium rate appropriate to the measured difference in each plan's benefit package value.

Strategy 2 assumes that limited multiple choice in plans is a policy objective. Under this strategy, several options would be created explicitly, as a part of the program structure, rather than be allowed to evolve through a combination of policy decision and market response.

1. Benefit Design

In *strategy 2*, benefit packages would be more rigorously determined. Several variations on this theme are possible:

a. Three to five options with minimum benefit specified. In this variation, several plans could be incorporated into a restructured FEHBP. This could be accomplished by permitting insurance carriers to offer packages to the administering agency, which would then select a specific number for inclusion in the program. Each plan would have to meet certain predetermined minimum standards of coverage. This approach would retain some element of choice among benefit packages while preventing individuals from assuming a level of risk determined undesirable as a matter of policy.

While this approach would greatly reduce the enrollee confusion over plan choices that appears to trouble the current program, some difficulty in choosing could still be expected as the plans distinguished themselves in the offering of benefits, both to meet the minimum requirements and to offer additional benefits. Thus, to some extent at least, the problem of risk segmentation would likely recur.

**b. Core option with supplements.* One way to retain some of the current choice among different plan sponsors, while limiting the risk segmentation that occurs when enrollees choose among different benefit packages, is to specify a core benefit package rather than allow plans to meet minimum standards through a variety of alternatives. In order to allow some degree of flexibility in the range of services covered, this approach could be combined with the liberty for plans to offer additional benefits beyond the core package.

The primary difference between a minimum package and a core package lies in the discretion left for plans to vary designs. In a minimum package, the minimums can be met or exceeded by different combinations. In the core plan, the actual benefits offered are specifically stated.

By specifying the core package, this approach would reduce uncertain financial risk even more. Confusion among different packages would be lessened. This approach would limit risk segmentation considerably, but some segmentation would occur if individuals began to group around certain supplemental offerings. Premiums for that group could rise or fall depending on the age and health of the lives attracted to a particular option. Thus, this approach would still enable the program to evolve to a point whereby large numbers of people could have similar benefit protection while paying substantially different amounts for that protection.

The core option would have the following design:

- An overall plan deductible of $250 that applies to all covered services
- Coinsurance of 75 percent of a program R&C schedule
- Maximum out-of-pocket of $2,500 annually

The supplements would be:

- A dental plan offering full payment on routine care and 75 percent on other care. Up to $1,000 of orthodontia would be covered.
- A prescription drug plan paying all costs after a $2 copayment per prescription.
- A vision care program paying for examinations and 80% of the cost of lenses each year.

2. *Cost Control Measures*

The techniques for controlling costs discussed in strategy 1 are the same for *strategy 2*. However, because *strategy 2* implies greater program control over the administration and operation of the plans, these cost control measures would be easier to implement.

a. Specify control measures for all plans. Conversely, specifying a complete package of cost control measures could stifle experimentation and might actually cost more money to administer than necessary to achieve maximum effectiveness.

**b. Set minimum standards.* Setting minimum standards, rather than actually specifying all the controls that a plan must exercise, would give individual plans some leeway to experiment with alternative methods. This freedom could facilitate efforts to determine which specific controls provided the greatest savings in return for the cost of applying the controls.

c. Direct controls on providers. As was discussed in the context of *strategy 1*, direct controls on providers are highly controversial.

d. Current practice. The current cost control practice would be continued.

3. *Choices*

This strategy is based on the premise that multiple choice would be conducted within a fairly restricted set of conditions. Thus, this strategy contains the choices specified in the earlier discussion of *benefit design*.

**a. Core plan and supplements.* This is the basic design for this option. Variations that would increase or decrease the number of options are discussed above.

**b. No limit on HMOs.* For purposes of displaying a broad array of policy choices, this strategy is assumed to provide open access to HMOs, provided they meet the restrictions specified in the other components of the strategy.

4. Premium Shares

**a. Different Federal payments for core and supplement.* With one core option, the employer cost could be allocated in any reasonable manner. One approach would be to pay a substantial part of the cost of the core plan and a portion of the supplements. In this strategy, the Government would pay 100 percent of the cost of the core plan for employees and 75 percent for dependents, and a sufficient portion of the supplements to achieve a constant cost with current Government outlays for FEHBP. Another approach would be for the Government to pay as much as possible of the core plan and leave the entire cost of the supplements to the enrollees. This could also be priced at a constant cost to the Government.

b. Separate rates for different family sizes. Some private sector plans use this approach.

5. Treatment of Annuitants

**a. A separate medigap option.* The option would have the same total benefits as the current FEHBP, including prescription drugs, but the rate would depend only on the participants in the option. The Government would pay three-fourths of the cost of the medigap option.

b. Waive the Part B Medicare penalty. Many Federal annuitants are covered by Part A of Medicare but have not elected to be covered by Part B. These annuitants could now elect Part B coverage. Annuitants without Part B would not be able to receive sufficient coverage from the separate medigap option.

Because a separate medigap option changes the situation from what was obtained when they declined Part B, the Government would waive the Part B penalty.

c. Current practice. All annuitants would continue to be treated as others in the plan. Annuitants covered by Medicare would be included in the core option and be eligible to elect the supplements. Total rates, and the annuitant share, would be set on the cost of the core option.

6. Financing

**a. Self-insure with current reserve and administrative expense structure.* This step would make the program self insured and permit greater flexibility in setting rates and reserve levels.

If self insurance were adopted, the Government could still maintain the same reserve levels and avoid using general funds except as a temporary measure in the worst years. The law could specify that, regardless of the insurance arrangement, FEHBP costs would be subject to premium taxes.

b. Self insure without reserves. This approach would eliminate the yearly 3 percent add-on, or reserve cushion, and would liquidate current reserve accumulations. This change could occur gradually, or it could provide a one-time reduction in premium increases. Current reserves total some $1.2 billion, or about 10 percent of 1989 premiums.

**c. Disallow premium taxes.* Changing FEHBP to a self-insured basis would eliminate premium taxes unless there were a specific provision to continue them.

C. Strategy 3: A Typical Private Sector Plan

As has been mentioned, the typical private sector practice is to offer one plan, although, in most cases, employees are able to choose an HMO if one is offered. Thus, for most employees, their only choice in health benefits is in the method of delivery of health care services. In effect, these employees choose between the freedom to select providers and more comprehensive coverage from a specific group of providers. There are three reasons why employers do not offer wide choice in FFS plans:

- Employers provide health insurance for their employees as a group.

The history of employer-sponsored group health insurance has been one of employers seeking coverage of affordable benefits for the enterprise's employees (and dependents), either by purchasing insurance from one of several competing carriers, or by self insuring a specific package of benefits. Generally, the employer has the power to determine the package, or shares that power with labor organizations. In either case, the determination of the benefit package is of primary importance to the employer.

- Multiple-choice plans cause expensive administrative responsibilities.

Permitting employees to choose among several different health benefit packages entails both an "open season," during which such choice can be made, and communication of complex information, so that informed choices are possible. As a result, private sector employers would find it burdensome to give their workers a choice..

- Private sector employers typically pay all or most of the cost of coverage for the employee, and most of the cost for dependents.

Private sector employers pay most of the direct premium cost of the coverage provided. Thus, they choose to exercise considerable control over the extent of that coverage. Also as a labor cost of doing business, the employers' payments for employee health insurance are treated, for tax purposes, as a deductible expense. Federal employees pay a large part of their health care premiums out of after-tax dollars and thus have grounds for directing those premiums to specific plans of their choosing.

In recent years, more of the costs of private sector employer-based health insurance has been shifted to employees. Many firms have also taken steps to introduce cost control measures and to encourage or require employees to join HMOs in an effort to restrain the growth in health insurance cost. This increased cost to employees has made it easier for them to recognize that health insurance is a part of total compensation, and they have begun to press for more control over the distribution of funds among the different elements of that compensation.

To some extent, the increased choice entailed by the spread of flexible benefit plans is partly the result of employees bearing more of the cost of their health insurance and the desire to have that cost subtracted from pre-tax wages, a condition that prevailed when the total costs of the plan were paid by their employers. Federal employees, on the other hand, have always paid a substantial part of the premiums for their health insurance, and out of after-tax income.

1. Benefit Design

In *strategy 3*, the general design follows closely the practices found most typically in the private sector. There is one benefit package, with HMO options where locally available.

**a. One plan, specified design.* Because there is one plan, the benefit package is specified. This plan would have the following benefit structure:

- Hospital/surgical expenses paid in full
- $100 deductible
- 80 percent coinsurance
- $1,000 out-of-pocket maximum
- Prescription drug coverage
- A dental plan with full payment of preventive care expenses; 80 percent payment for less expensive procedures; and 50 percent for more expensive procedures.

2. Cost Control Measures

Strategy 3, the single plan approach, could incorporate cost control measures as part of its basic design.

a. Specify cost controls. It may be argued that particular standards specified at the program level may mitigate pressures on local claims administrators to relax the interpretation of minimum standards.

*b. *Direct controls on providers.* Certainly, one plan would make bargaining with providers over charges more effective, given the size of the consumer population affected by the results. Furthermore, any effort to directly control the use of services or the charges for them has more probability for success if the authority to administer the insurance coverage is centralized in one plan.

3. *Choice*

The general approach of *strategy 3* is to mirror the prevailing private sector approach of providing one FFS plan.

*a. *Number of health maintenance organizations: limited.* Plans with fewer than 300 members would be terminated unless there were no other plans in their service area. All other current plans would be allowed to continue. New plans would be accepted only if they added significant new choices to the enrollees in the service area.

4. *Premium Shares*

a. The FY90 President's budget proposal. This strategy would probably require the Administration to modify the proposal. Otherwise, OPM's enrollment-weighted approach would simply blend the premiums between one FFS plan and a substantial number of HMOs. Unless the portion of FEHBP enrollees in HMOs were to climb substantially above the current 30 percent level, the FFS plan would essentially determine the cost to the Government.

*b. *Private sector practice of full Government payment for employee and 75 percent for dependents.* Assuming no change in current FEHBP enrollment levels, adopting this strategy would drive the Government's share of total premiums up from 70 percent of total premiums to about 87 percent. But enrollment levels would increase by 450,000 since eligible Federal workers who have refused FEHBP coverage would take advantage of the new financing arrangement.

c. Separate rates for different family sizes. This would remain an equity question.

5. *Treatment of Annuitants*

*a. *A separate medigap option.* The option would have the same benefits as the employee plan but the rate would depend only on the participants in the option. The Government would pay three-fourths of the cost of the medigap option.

b. Waive or pay the Part B Medicare penalty. Many Federal annuitants are covered by Part A of Medicare but have not elected to be covered by Part B. These annuitants could now elect Part B coverage. Annuitants without Part B could not receive sufficient coverage from the separate Medicare option.

Because a separate medigap option changes the situation from what was obtained when they declined Part B, the Government would waive the Part B penalty.

c. Current practice. Annuitants covered by Medicare would be included in the employee option. Total rates, and the annuitant share, would be set on the cost of the core option.

6. Financing

a. Self-insure with current reserve and administrative expense structure. This step would recognize the de facto self-insurance nature of the program and permit greater flexibility in setting rates and reserve levels.

If self insurance were adopted, the Government could still maintain the same general reserve levels and avoid using general funds except as a temporary measure in the worst years. Risk charges would no longer be necessary, but there would have to be some provision for profit as a cost of doing business. The law could specify that, irrespective of the insurance arrangement, FEHBP costs would be subject to premium tax, so as to not reduce revenues to State budgets.

**b. Self-insure without reserves.* This approach would eliminate the yearly 3 percent add-on, or reserve cushion, and would liquidate current reserve accumulations. This change could occur gradually, or it could provide a one-time reduction in premium increases.

**c. Disallow premium taxes.* Changing FEHBP to a self-insured basis would eliminate the premium taxes unless there were a specific provision to continue them.

IV. COSTS OF ILLUSTRATIVE STRATEGIES

This section displays sample projections of costs of the three strategies. Included are demonstrations of the relative effects on the baseline provisions in each strategy if certain variations are substituted for ones in the baseline set. Each substitute variation is projected holding all other provisions in the baseline set constant.

A. Costs of Baseline Provisions for the Three Strategies Compared to Current FEHBP

1. Categories Subsumed in the Summary Tables

Table 3.2 compares the baseline costs of the current FEHBP to the costs of the three strategies, using the baseline provisions of each strategy. This table represents a sample analytic presentation of how cost changes from different proposals could be shown as various alternatives are considered. These are summary tables that combine important categories of costs that would need to be broken out of the data in order for the full effects of the proposals to be fully understood. The following categories have been combined to produce these tables:

- Postal workers have been combined with the rest of the Federal workforce.

The collective bargaining agreements establishing the employer share of total plan premiums, in combination with risk segmentation and the current Big Six formula, have resulted in an average premium share of approximately 87.3 percent for the Postal Service and approximately 12.7 percent for the average postal worker. When postal workers are included with the rest of the enrollee population, the average enrollee share is 70.6. When postal workers are excluded, and the rest of the employee population is measured separately, their average premium share becomes 71 percent. These tables assume that, for *strategy 1*, the distribution of premium costs would put postal workers and others in the same relative position that they now hold. *Strategies 2 and 3* assume that postal workers would pay premiums equal to others in the program.

- Self Only and Family coverage has been combined.

Individual enrollees can choose to provide Family coverage or they can select Self Only coverage. This table combines the different premiums for Self Only and Family coverage, and presents them as the weighted average of the premiums for the two population groups. In the private sector, the weighted average of the different plans in the data base out of which the "typical" plan was created show an average enrollee premium that represents about 87.2 percent of total premiums when the weighted average of dependent coverage is included with other enrollees. This is the average effect of a plan in which the employer pays full costs for worker coverage and about 75 percent for dependent coverage.

- Retiree premiums are reflected in the average enrollee premiums.

The three strategies assume that retirees would have an opportunity to select "medigap" policies that in combination with Medicare, would give these retirees average total benefits equal to average benefits provided under the current coordination of coverage between FEHBP and Medicare. The premiums they would pay would depend upon the specific proposal, but for purposes of table 3.2 their total share would remain as it is under the current program, although it could also be assumed that a reduction in their share is an increase in the average share of other enrollees.

- Current employees now electing to waive coverage under FEHBP would be included in some of these scenarios.

Currently, about 16 percent of eligible employees do not elect to participate in FEHBP, thereby waiving the share of premiums that would be paid by the Federal Government were they to enroll. Under scenarios that show the effects of the Federal Government paying 100 percent of the premium for Self Only coverage, these employees are assumed to participate, and a corresponding increase in costs for them is shown. If a nominal premium is required, then some of these nonparticipants would continue to waive coverage.

In addition, about 500,000 retirees are not enrolled in FEHBP and under current law have lost their eligibility to elect coverage. The tables do not assume that an opportunity would be given to them to restore their enrollment in FEHBP. If such an opportunity were given, then additional costs would result, the level of which would depend on the type of opportunity they were given.

It is important to appreciate that this table does not provide data on the distributional effects, either on plans or enrollees, of the three strategies. There are such effects implicit in these estimates, but the analysis of them would entail examining the proposals with more detail than can be presented in this report. The capability for such distributional analysis exists in the methodology and can be applied as certain proposals became the subject for more thorough examination.

2. *Format for Presentation of Summary Cost Effects*

Table 3.2 compares the three strategies to the current program in four ways:

a. Cost of the current FEHBP to the baseline provisions of the three strategies. Under this comparison, the provisions are projected using the baseline provisions as specified in chart 3.1 on p. 65.

In ***strategy 1***, the additional costs entailed by the requirement that benefit designs meet minimum standards are partially offset by the incorporation of more stringent cost controls than are now in place. Because of the change in the formula computing the Federal share of plan premiums, more costs are shifted to enrollees.

Strategy 2 provides a core plan in which the entire costs of the premium are paid for employees, and 75 percent are paid for the premiums of dependents. Three additional supplements are offered for prescription drugs, vision care, and dental care. These supplements are almost entirely paid by the enrollees selecting them. An actuarial assumption based on private sector experience is used to determine the level of participation in these supplements. Because of the fully-paid coverage for employees, the 450,000 employees waiving coverage would now participate in the core plan. The weighted average of all enrollee premiums would be $910 per year, although employees could limit their premium expenses by taking only the basic core coverage. This premium reflects the fairly high cost of the supplements for prescription drug coverage and dental benefits used in the presentation of ***strategy 2***. The dental supplement is more generous than is now available under FEHBP plans.

Strategy 3 is the "typical" private sector plan applied to the Federal workforce. Because of the more generous benefit package in the typical private sector plan, the total costs of this strategy are higher than for the other two strategies and the current program. This strategy also assumes that the 450,000 employees waiving coverage would re-enter the program. This plan assumes that the weighted average (87.2 percent) of employer payments to the plan would apply, and that the more stringent cost controls and the absence of the need to maintain reserves through the assumption of self insurance would yield savings that would be passed to the enrollees in lower overall premiums, including coverage for retirees and dependents.

b. At constant Government cost. Total costs of the three strategies vary, but section (b.) of the table assume that the Federal cost of the program would remain constant. This approach would imply that any changes in costs created by particular treatment of perceived problems would be redistributed among enrollees.

Strategy 1 has a total cost near to that of the current program, but the change in the Big Six formula would change the way in which plans are subsidized by the Federal payments, which would also change the distribution of participants in the plans. The effect of this approach on enrollees is complicated, and would thus depend on the combination of changes that were adopted.

Strategy 2 is a core plan with supplements. In section (b) of table 3.2, the Federal cost is raised compared to that of section (a), and the money is assumed to apply to the supplement, thereby reducing the average enrollee premium accordingly.

Strategy 3, the private sector approach, assumes the generosity in the benefit package of the typical private sector plan, but the premiums are divided between the Federal Government and enrollees to achieve a cost constant with that of the current program. Consequently, the 450,000 nonparticipating employees would continue to waive coverage.

c. At constant enrollee cost. This approach assumes that changes to the program could entail higher costs, but that average enrollee premiums would remain the same. Nevertheless, additional program costs could still be redistributed among enrollees.

Strategy 1 has total costs close to the present system, and so there is not much shifting between the Government and the average enrollee under section (c) compared to either of the two preceding sections. The small additional costs are borne by the Government.

Strategy 2 assumes that the enrollee costs will be paid through the supplements. Because this strategy assumes that the core plan is primarily employer-paid, the enrollee premiums reflect participation in the supplemental plans.

Strategy 3 assumes a higher Federal cost than was shown for this strategy under section (b), but the enrollee share is still high enough to prevent the return of the nonparticipating employees.

d. At private sector cost sharing. In this approach, the costs of the strategies and of the current FEHBP are assumed to be shared according to the weighted average projected for the typical private sector plan.

The total premiums of the ***Current FEHBP*** are divided between the Federal Government and the average enrollee by 70.6 percent and 29.4 percent, respectively. To achieve consistency in the presentation, this distribution is changed to reflect the split of premiums assumed for the private sector plan. Enrollees would pay an average of 12.8 percent, but these reductions are shared by all enrollees, instead of employees being given a free Self Only option. Thus, the nonparticipating workers are assumed not to elect coverage. If the free Self Only option were provided, and the 450,000 workers joined the program, total costs would increase by around 5 percent above the total shown in the table under section (d).

Strategy 1 costs would increase because of the additional costs of the 450,000 workers re-entering the program.

Strategy 2 would increase costs for the Federal Government and reduce costs for enrollees. These smaller enrollee costs under section (d) relative to those of preceding sections, assume a higher Federal subsidy for the supplemental plans, and a corresponding higher rate of enrollee participation in them.

Strategy 3 assumes that savings from more stringent cost controls and the absence of reserves would be shared by the Federal Government and the average enrollee.

TABLE 3.2. Current Cost of FEHBP Compared to Three Strategies for Reform: Four Different Scenarios ($ in billions)

	Current FEHBP	Strategy 1	Strategy 2	Strategy 3
a. Cost of current FEHBP compared to three strategies:				
Total program cost	$11.60	$11.63	$11.69	$13.28
Government share	$8.19	$7.55	$8.04	$12.65
Government share as % of total	70.6%	64.9%	68.8%	95.3%
Enrollee share	$3.41	$4.08	$3.65	$0.63
Average enrollee cost	$850	$1,017	$818	$141
Percent change in average enrollee cost	--	+19.6%	-3.8%	-83.4%
b. At constant Government cost:				
Total program cost	$11.60	$11.63	$11.69	$12.60
Government share	$8.19	$8.19	$8.19	$8.19
Government share as % of total	70.6%	70.4%	70.1%	65.0%
Enrollee share	$3.41	$3.44	$3.50	$4.41
Average enrollee cost	$850	$857	$784	$1,099
Percent change in average enrollee cost	--	+0.9%	-7.7%	+29.3%
c. At constant average enrollee cost:				
Total program cost	$11.60	$11.63	$11.69	$12.60
Government share	$8.19	$8.22	$7.90	$9.19
Government share as % of total	70.6%	70.7%	67.6%	72.9%
Enrollee share	$3.41	$3.41	$3.79	$3.41

TABLE 3.2. Current Cost of FEHBP Compared to Three Strategies for Reform: Four Different Scenarios ($ in billion)--Continued

	Current FEHBP	Strategy 1	Strategy 2	Strategy 3
Average enrollee cost	$850	$850	$850	$850
Percent change in average enrollee cost	0.0%	0.0%	0.0%	0.0%
d. Cost if Government followed typical private sector practice:				
Total program cost	$12.19	$12.22	$11.69	$13.28
Government share	$10.62	$10.66	$10.19	$11.58
Government share as % of total	87.2%	87.2%	87.2%	87.2%
Enrollee share	$1.57	$1.56	$1.50	$1.70
Average enrollee cost	$350	$350	$335	$381
Percent change in average enrollee cost	-58.9%	-58.8%	-60.5%	-55.2%

NOTE: The current program covers 4,013,00 enrollees. If the entire cost of the enrollee coverage were paid, an additional 450,000 would be covered. Therefore, the coverage if the private sector approach is used is 4,463,000.

3. Summary Effects of Three Strategies

Strategy 1:

a. Benefit design. The introduction of minimum standards will increase the cost of FEHBP to the extent that options have to increase their benefits. The projection assumes that there would not be any offsetting reductions in plan design.

b. Cost control measures. The effect of cost control measures will vary by the type of measure and the extent to which it is mandated. The following assumes that the Government would specify and monitor the most promising control features. The lowest level of savings would occur if a minimum standard were set but left to the plans to adopt and monitor. The highest level would be direct control of the measures by the Government.

c. Choice. If union plans were limited to members, the Government cost would increase because more enrollees would be in options that were not limited by the 75 percent contribution lid.

d. Premium shares. Government costs would be reduced substantially if the contribution were based on the weighted average of the plans rather than on the Big Six. The use of risk adjusters would increase Government costs since the primary increase would be on the lower cost plans that are now under the 75 percent limit. The enrollee rates and separate family rates could be set to have no cost impact.

e. Treatment of annuitants. Moving Medicare annuitants to a separate option, and paying 75 percent of the cost of that option, would increase Government cost since they would be receiving higher payments than under the current plan.

f. Financing. Self insurance by itself would not reduce cost unless the reserve policy or allowable expenses were changed. If the additional contribution to the reserve were eliminated, there would be savings each year. Additional one-time savings could be achieved by letting the reserves draw down to zero.

Strategy 2:

a. Benefit design. The total insurance available would be close in cost to that of the private sector plan. However, costs would be reduced because enrollees could opt out of the supplemental coverage. The net result would be a small increase over the total cost of the current system.

b. Cost control measures. Strategy 2 has the same range of cost controls as in *strategy 1.*

c. Choice. Since all enrollees would be covered by the same core benefits, with the same available supplements, the cost would not be affected by the insurance arrangement.

d. Premium shares. Under this strategy, the Government pays the same total amount as under the current FEHBP. This would pay 100 percent for employee coverage, 75 percent for dependent coverage under the core and a small (5 percent) portion of the supplement. The Government would pay less if the enrollee paid the full cost of the supplement.

e. Annuitants. Strategy 2 has the same range of annuitant options as *strategy 1.*

f. Financing. Strategy 2 has the same range of financing options as *strategy 1.*

Strategy 3: Effects on Costs

a. Benefit design. The total insurance program would be more expensive than the current FEHBP because of the better benefits available in the private sector plan.

b. Cost control measures. **Strategy** 3 has the same range of cost controls as in *strategy 1.*

c. Choice. Since all enrollees would be covered by the same plan, the cost would not be affected by the insurance arrangement.

d. Premium shares. The Government would pay all of the cost for the enrollee's coverage and 75 percent of the additional cost for dependents. This would increase the cost substantially over the current FEHBP with the Government paying 71 percent of the average cost of the plans. The free enrollee option would also increase costs because the 450,000 who have waived coverage would take the free option.

e. Annuitants. Strategy 3 has the same range of annuitant options as *strategy 1.*

f. Financing. Strategy 3 has the same range of financing options as *strategy 1.*

B. Effects on Costs of Variations in the Six Components

The effect of variations to the baseline provisions is shown in tables 3.3 through 3.5. In each case, the effect is the result of introducing the change into the baseline, while holding constant all other provisions of the baseline set of provisions. The columns show the effect of the change on the cost of total premiums, the respective shares for the Federal Government and average enrollees, and the percent change to each. The baseline comparison assumes the pattern of premium sharing assumed under section (a) of table 3.2 except for the entry "**premium shares**" in table 3.5. This entry compares the change in the Big Six formula, to a formula in which the Federal Government pays the full cost of Self Only and 75 percent of Family coverage.

TABLE 3.3. Costs of Strategy 1 After Introducing Specific Variations into Strategy Baseline ($ in billions)

	Gov't cost	Enrollee cost	Total cost	% change from current FEHBP	
				Gov't	Enrollee
Benefit design					
Same for all plans	$7.55	$4.08	$11.63	-7.8%	19.6%
Core package	7.55	4.08	11.63	-7.8	19.6
* Minimum standards	7.55	4.08	11.63	-7.8	19.6
No change	7.47	4.04	11.51	-8.8	18.5
Cost control measures					
Specify controls	7.49	4.05	11.53	-8.6	18.7
* Minimum standards	7.55	4.08	11.63	-7.8	19.6
Direct controls	7.30	3.95	11.25	-10.8	15.7
No change	7.63	4.12	11.75	-6.9	20.8
Choice					
* Strategy 1 total	7.55	4.08	11.63	-7.8	19.6
No limit on unions	7.31	4.32	11.63	-10.7	26.7
Keep all options	7.57	4.10	11.66	-7.6	20.1
No limit on HMOs	7.55	4.08	11.63	-7.8	19.6
No change	7.33	4.33	11.66	-10.5	27.1
Premium shares					
* 60% of weighted average	7.55	4.08	11.63	-7.8	19.5
Use of risk adjusters	7.65	3.98	11.63	-6.6	16.7
Specify enrollee rates	7.55	4.08	11.63	-7.8	19.6
Separate family rates	7.55	4.08	11.63	-7.8	19.6
No change	7.45	4.18	11.63	-9.0	22.6
Annuitants					
* Separate Medicare option	7.55	4.08	11.63	-7.8	19.5
Purchase Part B	7.59	4.08	11.67	-7.4	19.6
No change	7.26	4.37	11.63	-11.4	28.2
Financing					
* Self insure with reserves	7.55	4.08	11.63	-7.8	19.5
Self insure without reserves	7.29	3.93	11.22	-11.0	15.2
Disallow taxes	7.48	4.05	11.53	-8.7	18.8
No change	7.55	4.08	11.63	-7.8	19.6

*Baseline provision.

Source: FEHBP Model.

TABLE 3.4. Costs of Strategy 2 After Introducing Specific Variations into Strategy Baseline ($ in billions)

	Gov't cost	Enrollee cost	Total cost	% change from current FEHBP	
				Gov't	Enrollee
Benefit design					
* Core and supplements	$8.04	$3.65	$11.69	-1.8%	7.0%
Five plans	8.04	3.65	11.69	-1.8	7.0
One plan	8.04	3.65	11.69	-1.8	7.0
Cost control measures					
* Specify controls	8.04	3.65	11.69	-1.8	7.0
Minimum standards	8.19	3.50	11.90	0.0	2.7
Direct controls	7.92	3.59	11.51	-3.3	5.4
Current practice	8.27	3.75	12.02	0.9	10.0
Choice					
Core and supplements	8.04	3.65	11.69	-1.8	7.0
No limit on HMOs	8.04	3.65	11.69	-1.8	7.0
Different insurers	8.04	3.65	11.69	-1.8	7.0
Premium shares					
* Strategy 2 total	8.04	3.65	11.69	-1.8	7.0
Separate family rates	8.04	3.65	11.69	-1.8	7.0
Annuitants					
* Separate Medicare option	8.04	3.65	11.69	-1.8	7.0
Purchase Part B	8.08	3.65	11.73	-1.3	7.0
No separate option	7.69	4.00	11.69	-6.1	17.3
Financing					
* Self insure with reserves	8.04	3.65	11.69	-1.8	7.0
Self insure without reserves	7.76	3.52	11.28	-5.3	3.2
* Disallow taxes	8.04	3.65	11.69	-1.8	7.0

*Baseline provision.

Source: FEHBP Model.

TABLE 3.5. Costs of Strategy 3 After Introducing Specific Variations into Strategy Baseline ($ in billions)

	Gov't cost	Enrollee cost	Total cost	% change from current FEHBP	
				Gov't	Enrollee
Benefit design					
* Typical private sector . .	$12.65	$0.63	$13.28	54.4%	-81.4%
Cost control measures					
Specify controls	12.81	0.63	13.45	56.4	-81.4
* Direct controls	12.65	0.63	13.28	54.4	-81.7
Current practice	13.18	0.65	13.84	60.9	-8.9
Choice					
* Typical private sector . .	12.65	0.63	13.28	54.4	-81.7
No limit on HMOs	12.65	0.63	13.28	54.4	-81.7
Premium shares					
60% of total	7.56	5.03	12.60	-7.7	47.6
Separate family rates . .	12.65	0.63	13.28	54.4	-81.7
* Typical private sector . .	12.65	0.63	13.28	54.4	-81.7
Annuitants					
* Separate Medicare option	12.65	0.63	13.28	54.4	-81.7
Purchase Part B	12.69	0.63	13.32	54.9	-81.7
Current practice	12.65	0.63	13.28	54.4	-81.7
Financing					
Self insure with reserves	13.20	0.65	13.87	61.2	-80.8
* Self insure without reserves	12.65	0.63	13.28	54.4	-81.7
* Disallow taxes	12.65	0.63	13.28	54.4	-81.7

*Baseline provision.

Source: FEHBP Model.

C. Distribution of Enrollees by Type of Plan

The three strategies assume changes to the current FEHBP that would have corresponding effects on likely enrollments. This table shows a sample presentation of how enrollments might be distributed in various plans as a result of the changes. This table incorporates data on the likely response of enrollees to changes in the relative value of their benefits or premiums. As stated previously, additional data on specific distributional effects awaits sufficient elaboration of the provisions of a specific proposal, so that the changes in relative advantages and burdens can be more precisely analyzed.

TABLE 3.6a. Current Distribution of FEHBP Enrollees among Plan Types (in thousands)

	FFS			
	Other	Empl. org.	HMOs	All plans
Annuitants:				
With Medicare	549	69	179	797
Without Medicare	391	225	119	735
Total	943	423	166	1,532
Employees:				
Nonpostal	589	699	494	1,782
Postal	120	364	215	699
Total	709	1,063	709	2,481
Total	1,652	1,486	875	4,013

Source: FEHBP Model.

TABLE 3.6b. Distribution of FEHBP Enrollees among Plan Types, Strategy 1 (in thousands)

	FFS			
	Other	Empl. org.	HM0s	All plans
Annuitants:				
With Medicare[a]	0	0	0	797
Without Medicare	489	121	125	735
Total	489	121	125	1,532
Employees:				
Nonpostal	1,067	196	519	1,782
Postal	269	205	225	699
Total	1,336	401	744	2,481
Total	1,825	522	869	4,013

[a] Medicare annuitants would move to new options outside the current FEHBP structure.

Source: FEHBP Model.

TABLE 3.6c. Distribution of FEHBP Enrollees among Plan Types, Strategy 2 (in thousands)

	Core plan	HMOs	All plans
Annuitants:			
With Medicare[a]	797	0	797
Without Medicare	610	125	735
Total	1,407	125	1,532
Employees:			
Nonpostal	1,263	519	1,782
Postal	474	225	699
Total	1,737	744	2,481
Total	3,144	869	4,013

[a] Medicare annuitants would move to new options outside the current FEHBP structure.

Source: FEHBP Model.

TABLE 3.6d. Distribution of FEHBP Enrollees among Plan Types, Strategy 3 (in thousands)

	FFS	HMOs	All plans
Annuitants:			
With Medicare[a]	797	0	797
Without Medicare	610	125	735
Total	1,407	125	1,532
Employees:			
Nonpostal	1,263	519	1,782
Postal	474	225	699
Total	1,737	744	2,481
Total	3,144	869	4,013

[a] Medicare annuitants would move to new options outside the current FEHBP structure.

Source: FEHBP Model.

CHAPTER 4. DESIGN FEATURES OF HEALTH INSURANCE PLANS

A. Introduction and Summary

1. Introduction

The Federal Employees Health Benefits program (FEHBP) operates at two levels, the program level and the plan level. OPM administers the system at the program level; individual insurance carriers administer the health insurance plans. OPM's overall program responsibilities are to: negotiate premiums and plan design with carriers; establish rules pertaining to carriers concerning financial standards, cost controls, and marketing of plans to participants; administer the FEHBP Fund, including collecting premiums and disbursing them to the FEHBP carriers; and hold "open seasons" during which Federal employees and retirees may join the program or switch plans.

The insurance carriers' responsibilities are to: design the plans they market to Federal workers and retirees in accordance with negotiations with OPM; ensure the financial integrity of the plans and comply with Federal audit requirements; publish descriptive materials about plan features and costs; and process and pay claims.

About three-fourths of FEHBP participants are enrolled in fee-for-service (FFS) plans, with the remainder enrolled in HMOs. Because the large majority of FEHBP participants are in FFS plans, the discussion of plan designs covered in this chapter focuses on that type of plan.

The following section summarizes the important issues in FEHBP FFS plan design and describes the process used by OPM and the carriers to design plans. Section C gives general background information about the design features common to all FFS plans, public and private, how these features fit together, and issues pertaining to various plan features. Section D summarizes the similarities and differences among FEHBP FFS plan features and compares the differences in plan values. The final section analyzes the sensitivity of FEHBP premium costs to changes in the benefit package.

2. Summary

The following important points apply to FEHBP FFS plan design:

- *Legislative and regulatory specification of plan design features.* In order to provide a variety of FFS plans from which participants may choose coverage and to allow for innovation in plan design, Congress did not prescribe FEHBP FFS plan features; the law states only that such plans "may" cover certain general categories of care. Current regulations do not specify required or prohibited plan features, they only affirm OPM's authority to negotiate plan features with carriers.[17]

- *Covered services in FEHBP plans.* Although there are 30 different FFS benefit packages, they offer a fairly standard array of medical/surgical coverage. Most of the variation in covered services is in such things as dental coverage, well-baby care, care by certain medical practitioners, and coverage of home health care and care in skilled nursing facilities. These types of coverage are relatively new additions to insurable medical services because they are not the types of care for which insurance traditionally has been sought.

- *Enrollee cost sharing in FEHBP plans.* Enrollee cost sharing through deductibles and coinsurance is similar among most FEHBP FFS plans. However, four plans use a different design that includes no overall deductible and limited, flat payments for specified services ("scheduled allowances") instead of coinsurance. These plans are among those with lower benefit values and have lower premiums than most other FEHBP plans.

- *Hospital inpatient care cost containment.* About half of FEHBP FFS plans have some hospital utilization control requirements, but because FEHBP carriers attract participants by marketing their plans directly to enrollees and not to the employer, it is not in the carriers' competitive interest to strictly enforce utilization controls or to voluntarily include stringent hospital utilization controls and managed care procedures in their plans.

- *Comparative values of FEHBP Plans.* The variation in the premium costs for FEHBP FFS plans is much greater than the variation in the benefit values of those plans. Measured on a standardized enrolled population, the value of the most generous FEHBP FFS plan (Self Only coverage) is 42 percent greater than the least generous plan. In comparison, the actual 1989 premium of the most expensive plan is 264 percent greater than the premium of the least expensive plan (Self Only coverage).

- *Sensitivity of premiums to plan features.* The typical FEHBP plan would cost about 25 percent more if there were no overall deductible or coinsurance; reducing the typical overall deductible from $250 to $100 would increase premiums by about 5.8 percent. Elimination of the dental coverage typically included in FEHBP FFS plans would reduce the premium by 4.1 percent, while adopting more comprehensive dental coverage, such as that typically included in private employer plans, would increase premiums by about 9.2 percent.

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[17] The only specific requirements with which all plan designs currently must comply are: (1) plans may not pay for abortions unless the life of the mother is endangered and (2) plans must waive their deductibles and coinsurance requirements for enrollees covered by Medicare.

B. FEHBP Plan Design: Background

An important congressional objective for FEHBP was to encourage the development of a variety of different health insurance plans among which Federal workers and retirees could choose. When FEHBP was enacted in 1959, the Senate committee set forth principles the program should address with regard to the interests of employees. The committee wrote:

> Employees should . . . have freedom to select the kind of plan that they deem most suitable for their needs . . . [and] the committee considers it unwise to tie the Civil Service Commission's hands by specifying dollar maximums or to spell out in detail the specific benefit structures. The program should recognize the problems of the low income employee and be specifically designed to aid such employees in securing health benefits. (Senate Report No. 468, July 2, 1959.)

Thus, the legislation includes no prescriptions for FEHBP plan design beyond broad requirements for general categories of covered services.[18]

The original FEHBP legislation gave the Civil Service Commission (now OPM) the authority to seek a variety of plan designs and costs through annual contract negotiations with insurance carriers. The annual contract process begins with a solicitation from OPM to carriers for contract renewal (the solicitation is known as a "call letter"). In those letters, OPM specifies the general types of services or cost controls they would like carriers to include in their proposals for the coming year, but the letters do not require explicit plan designs. Once the carriers' proposals are submitted, OPM negotiates the overall design of each plan. It does not impose all the same requirements on all plans in order to maintain a variety of different insurance packages that fit participants with different needs, preferences and financial circumstances. Thus, from the outset, program policy has been directed away from standardization of plans or mandating of benefit packages.

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[18] 5 U.S.C., sec. 8904 states that benefits "may be of the following types:

(1) *Service Benefit Plan*--(A) hospital benefits; (B) surgical benefits; (C) in-hospital medical benefits; (D) ambulatory patient benefits; (E) supplemental benefits; (F) obstetrical benefits.

(2) *Indemnity Benefit Plan*--(A) hospital care; (B) surgical care and treatment; (C) medical care and treatment; (D) obstetrical benefits; (E) prescribed drugs, medicines, and prosthetic devices; (F) other medical supplies and services.

(3) *Employee Organization Plans*--Benefits of the types named under paragraph (1) or (2) of this section or both.

(4) *Comprehensive Medical Plans*--Benefits of the types named under paragraph (1) or (2) of this section or both."

As new health care concerns arise, trends in procedures emerge, or innovative approaches to insuring or delivering health care prove promising, OPM may allow or encourage new designs or coverage, but the agency seldom mandates specific plan features. For example, in 1981 OPM informed carriers that they were "interested in" coverage of maternity services by licensed or certified midwives and in benefits for dental care. Payment for midwife deliveries was encouraged with the expectation that money would be saved through reduced physician and hospital charges. Also in 1981, OPM specified that dental benefits could be added to plans, but that premium negotiations would seek to:

> . . . hold premium charges down through tradeoffs--reduction in, or elimination of, current benefits of equivalent cost and value--in exchange for new or improved benefits . . . . (OPM letter to carriers seeking renewal of contracts for 1982, dated March 30, 1981.)

The March 1988 call letter reflected concern about rising premiums. It specified that OPM would:

> . . . consider benefit change proposals only in the context of zero cost benefit tradeoffs [and was seeking] benefit packages . . . strong in the traditional areas of hospital, surgical and medical benefits [with] protection against significant and largely unforeseeable health care expenditures.

This letter also asked for no reduction in coverage of mental health and substance abuse, stipulated that, in general, no increase in dental or vision care benefits would be considered, and suggested that certain fertility procedures could be added, but only with a zero net cost result.

Over the years, as the characteristics of the participating population and utilization patterns have changed, as new medical technologies have emerged and costs have risen, OPM has sought to revise some of its general policies about the nature of the plans offered, with an eye to meeting different and evolving health care needs while containing costs in an increasingly costly industry. However, a fundamental dilemma of the program is that maintaining a variety of different benefit packages to suit different participant needs may not be a realistic goal in a program in which carriers compete for enrollees. No plan wants to appear substantially different from the others, since it would not be attractive to the bulk of participants who seek a fairly standard insurance plan. As a result, most FEHBP FFS plans do not differ much in their coverage of traditionally insured care or in cost sharing and hospital utilization controls (with the exception of the "scheduled allowance" plans). Plans attempt to distinguish themselves in the special or "fringe" benefits they cover (such as dental benefits or well-baby care), but OPM's cost-tradeoff requirements effectively limit significant differences in the types of services plans cover.

C. Design Features of Fee-for-Service Plans

1. Benefit Features of Plans

There are five categories of health insurance benefit design features, defined as follows:

1. *Covered services and excluded services.* Medical services for which the plan will pay all (or part) of the charges, versus those for which the plan pays nothing.

2. *Enrollee cost sharing,* including:

   -- *Deductibles.* Costs enrollees must pay for covered services before the plan begins to pick up its share;

   -- *Coinsurance.* The share of the allowable charges for covered services that the enrollee must pay after the plan deductible is met;

   -- *Copayments.* A specific dollar amount enrollees must pay for certain services.

3. *Limits on allowable charges.* Limits on the charges for covered services, specified either as a "reasonable and customary charge" against which the plan applies its coinsurance share or as a flat amount for a particular service ("scheduled allowance").

4. *Catastrophic protection.* Limitation of enrollee payments for coinsurance for covered services or in excess of certain specified amounts when extraordinary medical expenses are incurred.

5. *Plan maximums.* Limits on total annual or lifetime plan payments to an enrollee.

The first feature, covered services, is the only one that pertains to the actual provision of health care services; the others pertain to how the costs of services are divided between the plan and plan enrollees. Following is a discussion of these plan features, the role each plays in plan design, and, where applicable, issues about which there is ongoing policy debate concerning the effects certain features have on health care costs, utilization, and health maintenance.

a. Covered and excluded services. The major categories of medical services for which plans establish separate rules and conditions concerning coverage and payment are: (a) inpatient hospital services; (b) outpatient services; (c) mental health services (including inpatient and outpatient); and (d) specialized services.

Covered inpatient care generally includes most or all of the charges associated with hospitalization, including room and board, surgeon and physician charges, diagnostic tests and laboratory work, and medicines. Covered hospital charges may be limited to a certain number of days.

For outpatient care, plans cover physician and surgeon charges, diagnostic tests, and charges associated with accidental injuries.

Mental health services, both inpatient and outpatient, including treatment for substance abuse, are usually subject to special rules for coverage. Cost sharing and limitations on enrollee out-of-pocket payments for these services are also different from those used for general medical care.

Other services sometimes covered in insurance plans include prescription drugs, dental care, vision care, well-baby and child care, routine physical examinations, and care in an extended care facility or through a home health care service. Plans may also cover treatment by chiropractors, podiatrists, and other health practitioners. Some plans have implemented health promotion activities, including "wellness" programs and exercise or health education classes.

Services not covered by the plan are referred to as "excluded services," and any costs enrollees incur for excluded services are neither paid for by the plan nor applied toward the plan's deductible requirements or catastrophic limits (described below). Examples of services and expenses that are not covered under many health insurance plans are infertility services; cosmetic surgery; services not deemed "medically necessary" such as those done for educational, research, or vocational training purposes; experimental treatments; tests not needed for a particular condition; and services that do not meet generally accepted standards of medical practice. Plans may also specify the type of providers to whom payment can be made for covered services and may exclude treatment by others. For instance, a plan may pay for mental health services only if provided by a psychiatrist or psychologist.

b. Enrollee cost sharing. Important features typical of most health insurance plans are those aimed at keeping plan costs down by requiring enrollees to pay part of the cost of the covered services they use. These features are deductibles, coinsurance payments, and copayments; they are sometimes categorized as cost containment features rather than as benefit features. Before the 1980s, FFS health insurance plans generally reimbursed all costs of covered services. However, escalating health care costs called this practice into question, and plan sponsors and insurers sought ways to make consumers more aware of the cost of the services they used.

In addition to saving money for the plan by requiring enrollees to pay for part of the cost of care, enrollee cost-sharing features also attempt to limit use, thereby saving costs, in different ways. Deductibles, which are common in many different types of insurance, are designed to discourage the initial use of health services and the filing of small claims; coinsurance can encourage enrollees to seek the least expensive form of treatment or to limit the use of health care services. Cost-sharing requirements became common among FFS plans in the early 1980s. For the 1982 plan year OPM required all FEHBP plans to reduce their premium costs, and, to achieve that goal, FEHBP plans added coinsurance and deductibles in order to shift a portion of the cost of the program, which was rising rapidly, from the Government (as employer) to the enrollees.

Other plan features that affect participant costs are enrollee protection against catastrophic expenses associated with a major illness or injury, and maximum plan payments that limit the plan's liability. Following is a description of how enrollee cost-sharing features work and some of the issues currently debated by health plan designers about the effects of these features.

(1) Deductibles. Within a calendar year, enrollees are usually responsible for a specified amount of covered charges before the plan pays benefits. This amount is the "overall deductible." For instance, a plan may require that an enrollee pay the first $200 of covered expenses each year. For Family coverage, a separate deductible may be required for each family member, but there is generally a cap on the deductibles required for a family. A separate "admission deductible" may be applied for inpatient hospital care and is intended to discourage unnecessary hospital admissions and reduce plan hospital costs.

Some believe that although outpatient deductibles discourage use of unnecessary care, they may have the perverse effect of discouraging early diagnosis and treatment of legitimate medical problems, potentially leading to higher treatment costs later on. Thus, deductible levels are generally set at amounts that take into account not only cost control effects but also the effect on the health maintenance behavior of the enrolled group.

(2) Coinsurance. Enrollees in FFS plans are usually required to pay a portion of covered expenses after the deductible has been met. These are referred to as "coinsurance" payments. For instance, the enrollee may be required to pay 20 percent of covered charges after the deductible is met, and the plan pays the other 80 percent.[19] Plans typically use different coinsurance rates for different types of care, such as different rates for inpatient hospital care and outpatient care. In order to encourage outpatient treatment whenever feasible and discourage expensive hospitalization, enrollee

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[19] Insurance plans define "coinsurance" as the portion of the covered expenses paid by the insurer. For instance, "80 percent coinsurance" means that the insurer will pay 80 percent of the expenses and the insured will pay the other 20 percent. This report will use the more familiar concept of coinsurance as that portion paid by the insured. Thus, "20 percent coinsurance" will mean that 20 percent of the expense will be paid by the insured.

coinsurance rates for a certain procedure may be lower if it is done on an outpatient basis rather than on an inpatient basis. Mental health care usually has different coinsurance rates from medical/surgical care, and outpatient emergency room care may require no enrollee coinsurance payments.

Again, coinsurance rates are designed to control costs by limiting utilization and are generally set at levels that take into account the competing objectives of cost control and health maintenance.

(3) Copayments. Copayments are small charges enrollees may be required to pay for certain services, such as a $5 fee for all prescription drugs. Plans include copayments to promote enrollee awareness of the cost of services and to keep plan costs down for certain charges. Copayments are more commonly used by HMOs than by FFS plans, since HMOs generally have no coinsurance requirements for services.

(4) Limiting allowable charges for covered services. A technique used by virtually all FFS plans to control costs is limitation of allowable charges for covered physician and surgeon services to those defined by the plan as "reasonable and customary" (R&C)[20], or to a flat dollar amount, known as a "scheduled allowance" (SA) (sometimes referred to as a "relative value schedule"). Although use of an R&C scale is not always categorized as enrollee cost sharing, it has the effect of requiring enrollees to pay part of the cost of a covered service when a doctor charges more than the R&C or other allowable amount. Plans apply their coinsurance rates to the R&C charge for a given service or to the actual charge, whichever is lower. The enrollee pays any amount in excess of the R&C limit.

Plans may construct their own R&C charge limits, or they may use the Prevailing Health Care Charges System data collected and maintained by the Health Insurance Association of America (HIAA), an organization representing commercial health insurers. The HIAA collects service-specific claims data from commercial carriers throughout the nation who subscribe to their system. About 145 firms supply data, totaling some 60 million claims. Subscribers contract for this service. The contract specifies the nature of the data the subscriber will provide to HIAA and requires confidentiality in the subscriber's use of the information received from HIAA.

Every 6 months the HIAA collects new claims data, sorts it into 200 geographic areas, and ranks the distribution of charges by percentile. For example, for a given procedure, the data base shows the charge for that procedure below which 50 percent of all claims fall, below which 60 percent fall, 70 percent, 75 percent, etc., to 95 percent. Insurance carriers select the level at which they want to set their R&C limits. Most use the 90th percentile, but they may use different levels for different procedures. In general, most carriers, particularly the smaller firms and many FEHBP plans, rely on HIAA R&C rates. Some larger carriers, such as Blue Cross/Blue Shield and Aetna, collect their own claims data and construct their own R&C schedule which they use for their commercial clients and their FEHBP plans.

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[20] Different terminology, such as "usual, reasonable and customary" is sometimes used to describe this plan feature. However, this report will use "reasonable and customary" because that is the term used in OPM literature and by FEHBP carriers.

Instead of using deductibles, coinsurance and R&C limits, a few carriers (four in FEHBP) use a different design for determining plan payments and enrollee payments. These plans use a "scheduled allowance" to define the amount the plan will pay. An SA is a flat dollar amount that the plan pays for a given service. The enrollee is responsible for all charges in excess of the SA. SA plans under FEHBP are set at one amount that applies nationwide, thus effectively limiting reimbursements more for enrollees living in high cost areas than for those who live where medical costs are lower. Plan payment limits for most medical procedures are listed in the FEHBP plan brochures. Some plans use SAs only for dental care or well-baby care, and may use different SA limits for those services in different localities.

Critics of plans that use SAs for overall medical care say they expose enrollees to higher levels of risk than do other types of plans, and that enrollees may not realize the extent of the risk. Defenders of these types of plans say that they are an effective way to offer lower cost insurance to participants who are generally healthy, at low risk, and who cannot or prefer not to pay higher premiums for more protection against risk. They also note that under FEHBP all plans, including those that use SAs, provide protection against extraordinarily large medical bills through "catastrophic expense protection."

(5) Catastrophic expense protection. Most FFS health insurance plans offer protection from major enrollee health care bills by limiting the out-of-pocket expenses enrollees pay in a calendar year for coinsurance and, in some cases, deductibles. For instance, a "catastrophic limit" of $2,000 means that, after the coinsurance payments by the enrollee total $2,000, all additional covered expenses beyond $2,000 are paid by the plan without coinsurance charges. Some SA plans count all enrollee expenditures beyond the plan payment for covered services toward the catastrophic limit; others count the difference between the plan payment and an R&C limit. Plans usually have different catastrophic limits on costs of medical/surgical care and mental health care.

Concern is sometimes raised about the adequacy of the catastrophic expense protection in FEHBP plans because those limits generally do not apply to mental health care, do not take into account enrollee expenses for medical care or services not covered by the plan, and do not take into account charges in excess of the plan's R&C or other limits for which the enrollee is responsible. However, plan designers contend that, realistically, plans cannot offer 100 percent protection against all costs and all charges, and no plan claims to offer such protection. They say that the current design of catastrophic limits generally serve the intended purpose of providing substantial protection against extensive medical bills above specified amounts when major and unforseen illness or injury occurs. However, perhaps the most controversial and difficult catastrophic cost coverage issue is long-term custodial care, which is generally excluded from most traditional health insurance plans, including Medicare.

(6) Plan maximums. Some plans have annual or lifetime maximums they will pay on behalf of the enrollee and dependents. The plan will not pay for any health care after the total annual or lifetime payments by the insurer reach this maximum. In many cases, these limits are so high (e.g., $1 million) that they have virtually no effect. However, there are often separate, lower maximums on specific services such as mental health care.

2. *Cost and Utilization Control Features of Plans*

The cost of health care and health insurance is, and has been for some time, a major concern nationwide, and costs are continuing to rise despite efforts to contain the increases. Although deductibles and coinsurance reduce plan costs and appear to be somewhat effective in curtailing discretionary utilization for routine medical problems, different approaches are warranted for dealing with more serious conditions that may entail expensive surgery and hospitalization.

In recent years, insurance carriers have attempted to deal with the rising costs of inpatient care by playing a more active role in prospectively approving provision of certain services and in monitoring the use of inpatient treatment for major illnesses and injuries. Sometimes referred to as "managed care," these cost control measures attempt to ensure that care is provided at an appropriate level and that patients are not hospitalized unnecessarily. However, although managed care practices aimed at containing costs through utilization control appeal to carriers and to employers who generally pay most or all of the premium costs for their employees, these features are unpopular with enrollees. Thus, the trend toward implementing and strictly enforcing utilization controls in private employer-based plans is not reflected in FEHBP, because FEHBP carriers market their plans directly to enrollees who are likely to be skeptical of requirements that they seek second opinions or obtain approval from the plan before they can be hospitalized.

Application of prospective hospital payment systems for hospital reimbursement is another approach to containing the costs of hospitalization that has been used by Medicare (the Federal health program for the elderly and disabled) and was recently instituted in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for military retirees and dependents. These systems attempt to limit payments for inpatient hospital care by prospectively setting the amount a hospital will be paid for care of a patient with a given condition.

Following is a discussion of how managed care procedures are used tc constrain costs and how a prospective hospital payment system works.

a. Managed care. There are three general categories of utilization control or managed care that FFS plans use to contain the cost of inpatient care:

1. Second opinions for nonemergency surgery;

2. Hospitalization utilization review, including prehospitalization certification, concurrent utilization review, use of case managers, and posthospitalization utilization review; and

3. Hospitalization alternatives.

In instituting such cost controls on hospital utilization, insurance carriers, particularly FEHBP carriers who compete for enrollees, are concerned about striking a balance between ensuring that only appropriate, medically necessary care is provided and not unduly antagonizing enrollees.

(1) Second surgical opinions. If a plan enrollee voluntarily seeks a second opinion when surgery or hospitalization is recommended, many insurance plans will cover the cost. Some plans, including most of the FEHBP plans, require a second opinion in cases involving nonemergency surgery, and some cover a third opinion if needed to break a tie between the first two. In the event that a mandatory second opinion is not obtained, the plan will reduce the percentage of the charge it will cover for the surgery or may limit its payment to a flat amount. The purpose of second opinions is to obtain some degree of consensus that surgery is the best procedure and thereby avoid unnecessary surgery if another, less costly, course of treatment may be equally beneficial.[21]

Second opinions potentially save money by resulting in surgeries not performed, by some procedures being performed on an outpatient basis instead of in the hospital, and by more careful recommendations for surgery due to awareness of the program.

Questions are sometimes raised about the effectiveness of second opinions in curtailing costs. On the one hand, some maintain that second opinions are good health care policy, not only because they may save the cost of unnecessary surgery, but also because they protect the patient from the risk of surgery when it may not be required. On the other hand, others are concerned that requirement of a second opinion can jeopardize the physician-patient relationship. In general, voluntary second opinion programs have been reported as ineffective, largely because they are not used. This lack of use is due to enrollees being unaware of the program or being reluctant to question a physician's judgment.

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[21] Examples of procedures for which second opinions are often required include hysterectomy, tonsillectomy, mastectomy, cholecystectomy, hemorrhoidectomy, knee surgery, varicose vein stripping and ligation, hernia repair, spinal surgery, and prostatectomy.

(2) Hospitalization utilization review. Because inpatient hospital care can be extremely costly, health plans are beginning to incorporate hospitalization utilization review procedures. The basic objectives are to prevent unnecessary hospitalization and to ensure that the patient is being treated in the appropriate setting. Hospitalization utilization review has different components, including prehospitalization certification, concurrent review of continuing inpatient treatment after the patient has been admitted, use of case managers, and routine retrospective reviews of inpatient care. Carriers generally contract for utilization reviews with firms specializing in such activities.

Prehospitalization certification is a requirement that the patient obtain permission from the insurance plan before being admitted to a hospital for nonemergency treatment. Plans usually establish a procedure through which the plan enrollee can easily get in touch with personnel who perform this function.

Concurrent review of inpatient care is a cost containment practice that can be part of an overall utilization review program. A "case manager" or "nurse coordinator" is assigned to monitor and review ongoing hospitalization once admission has been approved, focusing primarily on the necessity for continued hospitalization versus moving the patient to a less costly facility such as an extended care facility or in-home nursing care. The role of the case manager may include determining the length of the hospital stay, given the diagnosis. The function of concurrent review is not to approve or second-guess the physician's treatment plan but to monitor the necessity for continued treatment in the hospital.

Retrospective review of inpatient care is aimed at reviewing the appropriateness of care that has been provided and may include determining whether all the costs should be reimbursed. It can also be used to develop data on hospitalization utilization patterns and to identify geographic areas or providers that tend to have utilization rates higher than the norm.

As with other cost containment measures aimed at decreasing the extent of unnecessarily costly hospital admissions and procedures, there is little conclusive evidence about the effectiveness of hospitalization reviews. There are certainly costs associated with staffing and carrying out such programs. Depending on how aggressive the utilization program is, and whether there is a coordinator or case manager who is located on site as opposed to one who approves treatment plans via telephone from a central location, the degree of intrusion into the physician's jurisdiction and medical judgment can vary. In general, hospitalization certification and review procedures may curtail unnecessary admissions and shorten hospital stays and may relieve the physician of having to make alternative arrangements for his or her patients. However, because certification and review pertain to medical judgment applied to individual cases, some believe there is a risk that overly rigid or generalized rules could prove detrimental to the best interest of the patient and may unduly antagonize the patient, the primary physician, or both.

(3) Hospitalization alternatives. Over the course of treatment for illness or injury, a patient may require ongoing medical services and attention but not the full level of services provided in a hospital. Thus, less costly facilities and services have become available and are covered by many insurance plans, including care in a skilled or extended care facility and home health care services. In order to encourage use of such facilities, some plans cover more of the cost of this type of care than of hospital care. Skilled or extended care facilities provide medical (not custodial) care when only limited care is required, but at daily room and board rates that can be substantially lower than those charged by hospitals. Such services may be used either instead of hospitalization or for posthospitalization care. However, most insurance plans place limitations on use of this type of care, such as limiting the total cost the plan will pay or restricting the length of a patient's stay in such a facility. In addition, most plans require that the facility meet certain standards for services and staffing such as those established by Medicare.

Skilled care provided in a patient's own home may be a good alternative to hospitalization for some types of treatment and can have the advantages of being both less expensive than care provided in a hospital and more comfortable for the patient. In general, when plans cover this alternative to inpatient care they require that it be prescribed by a physician and be subject to periodic review. Plans may also place limits on the number of home care visits that will be covered.

b. Prospective hospital payment systems. Prospective payment systems have a number of goals, one of which is to contain hospital costs by paying hospitals a predetermined, fixed rate per patient determined largely on the basis of the patient's diagnosis. This type of system is used in the Medicare program to constrain its payments for inpatient hospital services to elderly and disabled persons. The Federal Government pays hospitals for treatment of Medicare patients according to the "diagnosis related group" (DRG) into which the patient is classified. There are approximately 470 such DRGs for Medicare enrollees.

In 1987, CHAMPUS adopted a DRG-based prospective payment system for its approximately 7 million enrollees, who are the dependents of active duty military personnel, and military retirees who are not eligible for Medicare and their dependents. The CHAMPUS/DRG system applies to inpatient care received in a civilian hospital. CHAMPUS modeled its DRG program after Medicare's but modified the DRGs to reflect the generally younger CHAMPUS population. The CHAMPUS program is linked to the requirements and sanctions of Medicare.

Since hospitals are allowed to keep any difference between prospective payments and their actual costs and, under both Medicare and CHAMPUS, they may not bill patients for costs beyond those paid under the DRG system, there is an incentive for hospitals to manage patient care to stay within these cost limits. However, some analysts have questioned whether a system based on a fixed payment regardless of the services provided encourages a reduction in services, possibly reducing the quality of care provided.

It has been suggested that extension to FEHBP of a DRG-based prospective payment system patterned after Medicare and CHAMPUS could reduce hospital costs for Federal civilian employees and retirees. For example, hospitals that receive Federal reimbursement for Medicare patients could be required to accept a predetermined rate as payment for FEHBP enrollees, just as they do for CHAMPUS enrollees. Proponents of such a plan claim that savings would accrue to the extent that the payment rate was below hospital charges. Opponents question whether PPS/DRG arrangements save money overall or whether they cause hospitals to reduce inpatient costs but increase outpatient costs.

Several States have already implemented DRG systems as part of their State employee health plans, and General Motors has negotiated with about 50 hospitals in the Midwest to implement a DRG system within its employee health plan.[22]

D. Similarities and Differences Among FEHBP Fee-for-Service Plans

It is often said that FEHBP includes a bewildering array of plans with widely different benefit packages. However, careful review of the plans and options offered indicates that there are not many wide differences in the design features of FEHBP FFS plans, although a systematic approach to comparing services and costs is necessary to understand the choices.

FEHBP includes 22 different FFS health insurance plan carriers in 1989. Eight of these carriers offer two plans, a "high option" and a "standard option." Thus, altogether, there are 30 different FFS plans offered under FEHBP. Of these 30 plans, 9 are open only to members of specific employee groups, leaving a maximum of 21 different FFS plans from which any individual FEHBP participant may choose. (The maximum is 22 for an employee who happens to be a member of one of the special groups that offers its own plan. Such an individual can choose that special group plan or one of the 21 other FFS plans.)

This section compares (1) the important similarities and differences in the design features of the 30 FEHBP FFS plans and (2) the value of the different benefit packages.

1. Comparison of FEHBP Fee-for-Service Plan Features

a. Covered services. All FEHBP FFS plans cover the same basic services: inpatient and outpatient hospital care, physician services, surgical services, diagnostic tests, and accidental emergencies. Because FEHBP carriers compete for enrollees, it stands to reason that there would not be major differences among the plans in the basic services for which people seek health insurance. For example, a plan that covered no emergency care for accidents would not attract many enrollees.

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[22] States that have implemented a DRG approach for their employee health plans include Connecticut, Florida, Maryland, Massachusetts, New Jersey and New York.

Most of the differences in covered services are found in those things sometimes considered to be the "fringe benefits" of health insurance. For example, not all FEHBP plans cover well-baby care or routine care for children. Plans that do not cover this care would probably not be elected by young families, but, for participants without babies, well-baby care is of no value and they would look to another feature as the basis for their choice. Chiropractic services are covered by a few plans, but, with the exception of those people with chronic problems needing chiropractic care, it is not the type of health care expense most people seek to insure themselves against.

Twenty-six of the 30 FFS plans in FEHBP include dental care to some extent, but there is considerable variation in this coverage. Dental care is not the type of health care people have traditionally sought to insure against, since dental problems are unlikely to be catastrophic or life-threatening and are the type of expense for which an individual or family can usually budget. Thus, most FEHBP plans cover very limited dental charges, typically using SAs with low maximum payments for specified procedures. Most plans cover limited routine cleanings and check-ups, but a few cover more costly services such as caps and crowns, but with limited maximum payments.

All FEHBP plans offer some mental health care and substance abuse treatment but with widely differing provisions regarding the portion of such charges covered. Coverage of mental health care costs would be an important consideration for someone in need of such care, but it is a service used by a small portion of FEHBP enrollees, and it is unlikely that many make their health insurance plan choice on the basis of this feature.

Sixteen plans include both home health care and care in an extended care facility. Six cover only home health care as a hospital alternative, and two cover only care in an extended care facility. Six plans cover neither of these types of care. Plans vary substantially in the conditions set for coverage, such as restrictions on days of coverage, number of home visits and maximum allowable charge per home visit. Coinsurance rates also differ, but most pay 85 percent or more.

Finally, outpatient prescription drugs are covered by all but four plans, and many plans offer reduced price prescriptions by mail. Coverage of drugs would be an important plan feature for individuals who use maintenance prescriptions, but others may feel the cost of the incidental prescriptions they typically use in a year is not a major health cost factor.

b. Covered costs. FEHBP FFS plans also have the same basic array of features pertaining to enrollee cost-sharing: deductibles, coinsurance requirements, and catastrophic expense protection. Although these features differ among the plans, most of the plans are clustered around norms. For example, of the 17 plans available Government-wide that use an overall deductible, 11 have a deductible of $200 to $250 (table 4.1). (The four plans that have no overall deductible limit reimbursement to an SA per service.)

TABLE 4.1. Distribution of FEHBP Plan Overall Deductibles, 1989

Annual overall deductible	Number of plans
None	4
Under $200	2
$200-250	11
$251-300	2
Over $300	2

Source: OPM plan brochures for 1988 open season.

There are significant but not extreme variations in coinsurance rates for surgery, hospital costs, accidents and routine doctor visits, which are the services for which most people seek insurance protection. Table 4.2 on the following page shows the distribution of these rates for the Government-wide plans. Setting aside the plans that pay only SAs for surgeon and physician services and therefore do not specify coinsurance rates, plans generally pay 75 to 100 percent of these services.

In regard to catastrophic cost protection, eight plans limit the amount enrollees pay for coinsurance under Self Only coverage to $1,000 or $1,500 per person, per year, only one plan has a catastrophic limit as high as $3,000, while one plan places the limit under $1,000. Plans that use coinsurance and R&C limits do not apply any charges beyond their R&C limit toward the catastrophic limit. Plans that pay SAs apply catastrophic limits in one of two general ways: (1) they count all enrollee out-of-pocket costs for covered services in excess of the plan payment toward the catastrophic limit but exclude certain services, or (2) they count enrollee out-of-pocket costs for covered care between the plan payment and an R&C, excluding enrollee costs in excess of the R&C limit.

Figures 4.1 through 4.6 (following table 4.2) illustrate the distribution of enrollee cost-sharing features of FEHBP FFS plans. Figure 4.1 shows the overall deductibles in the 21 FEHBP plans available to all workers and retirees and demonstrates the clustering of deductible levels. Figure 4.2 illustrates the distribution of plan catastrophic expense limitations. Figures 4.3 through 4.6 illustrate plan coinsurance rates for selected health care services.

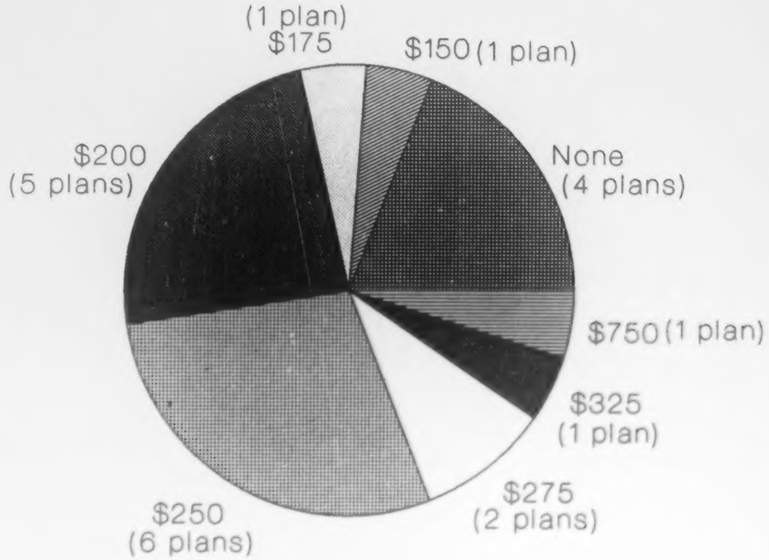
TABLE 4.2. Selected FEHBP Plan Coinsurance Rates, 1989

	Type of service			
Coinsurance rate	Inpatient surgeon	Inpatient room & board[a]	Outpatient doctor	Accidental injury
	(Number of plans)			
Scheduled allowance	5	0	4	5
75%	5	1	8	4
80%	5	1	6	1
85%	1	0	2	0
90%	2	1	0	0
100%	3	17	1	11

[a] One plan pays 70 percent of inpatient room and board.

Source: OPM plan brochures for 1988 open season.

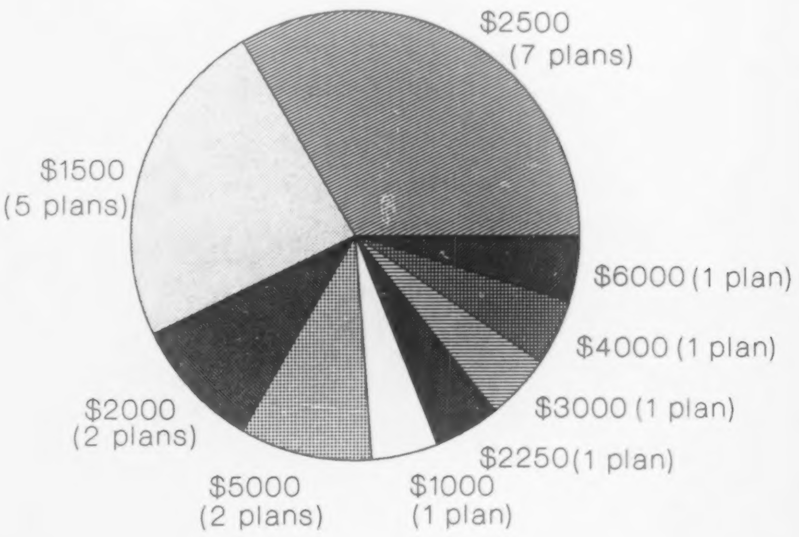
Figure 4.1. 1989 FEHBP Overall Deductibles



Note: Includes only those fee-for-service plans open to all employees and retirees Government-wide. Deductibles shown are for one individual. For family coverage, deductible amounts are typically capped at 2 persons.

Source: OPM 1989 Enrollment Information Guide, FEHB Plan Comparison Chart.

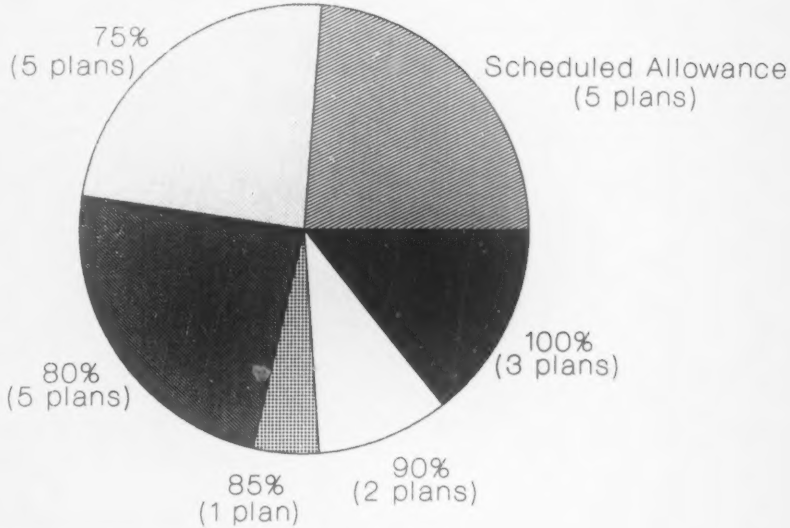
Figure 4.2. 1989 FEHBP Catastrophic Limits
(family coverage)
Maximum Enrollee Out-of-Pocket Expenditure



Note: Includes only those fee-for-service plans open to all employees and retirees Government-wide; excludes mental health care.

Source: OPM 1989 Enrollment Information Guide, FEHB Plan Comparison Chart.

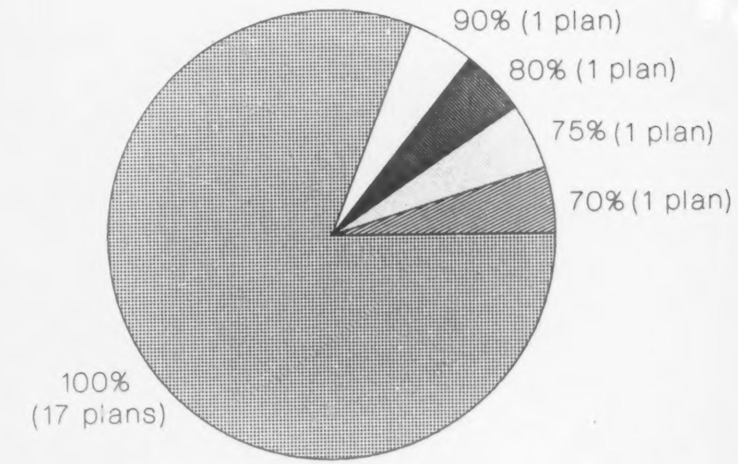
Figure 4.3. 1989 FEHBP Coinsurance Rates for Inpatient Surgeon Charges: Percent Plan Pays



Note: Includes only those fee-for-service plans open to all employees and retirees Government-wide.

Source: OPM 1989 Enrollment Information Guide, FEHB Plan Comparison Chart.

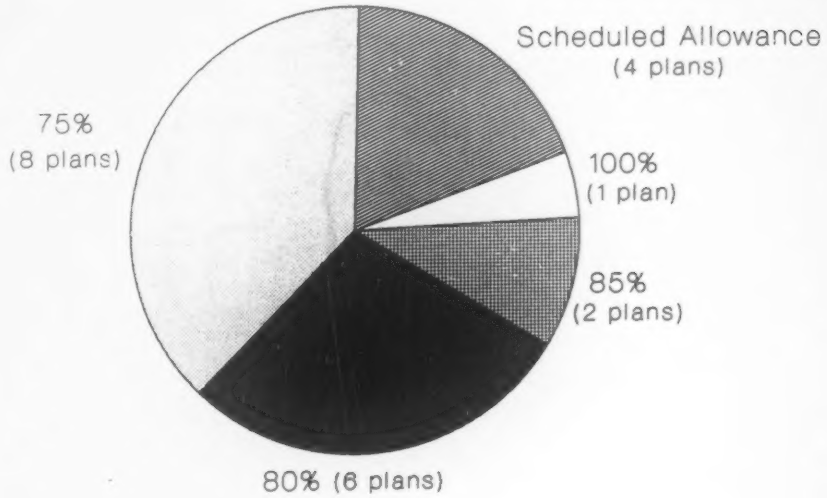
Figure 4.4. 1989 FEHBP Coinsurance Rates for Hospital Room and Board Charges: Percent Plan Pays



Note: Includes only those fee-for-service plans open to all employees and retirees Government-wide.

Source: OPM 1989 Enrollment Information Guide, FEHB Plan Comparison Chart.

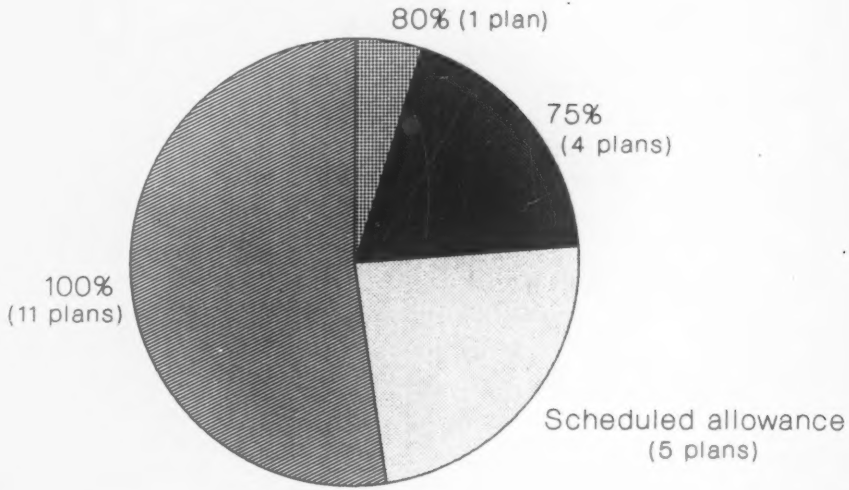
Figure 4.5. 1989 FEHBP Coinsurance Rates for Outpatient Care and Diagnostic Tests: Percent Plan Pays



Note: Includes only those fee-for-service plans open to all employees and retirees Government-wide.

Source: OPM 1989 Enrollment Information Guide, FEHB Plan Comparison Chart.

Figure 4.6. 1989 FEHBP Coinsurance Rates for Accidental Injury Outpatient Care: Percent Plan Pays



Note: Includes only those fee-for-service plans open to all employees and retirees Government-wide.

Source: OPM 1989 Enrollment Information Guide, FEHB Plan Comparison Chart.

A cost feature that differs among FEHBP plans, but that is not explained in the literature made available to enrollees or potential enrollees, is the R&C rate used to limit plan payments for various services. For example, several plans may cover a given service and state in their literature that they pay 80 percent of the R&C charge for that service, but the cost to the enrollee can be substantially different if the plans apply that coinsurance rate to a different R&C charge. Plans note a number or reasons for not publishing the R&C rates they use: (1) They are concerned that publicizing the maximum payable rate for a service or procedure will result in all billings for that service rising to that maximum (e.g., if it were widely known that a plan will pay up to $500 for an appendectomy in certain locality, all appendectomies there would cost $500); (2) R&Cs are updated frequently, potentially causing confusion about applicable current rates; and (3) those plans that contract with HIAA for R&C data are required to maintain confidentiality in the use of the data. This feature of FEHBP plans is probably one of the least understood, yet it is an extremely important determinant of enrollee out-of-pocket costs.

A plan that uses SAs to limit plan payments is a different basic design from a "typical" FFS plan that uses R&Cs. SA plans have no overall deductible but may require a deductible on selected services; they limit plan payments for most services to flat amounts but generally use coinsurance for emergency care; like typical FFS plans, they provide catastrophic expense protection, and may apply all enrollee out-of-pocket expenses for covered services toward that limit, or may apply only the difference between the plan payment and an R&C limit. Because SA plans pay less than typical FFS plans for routine care, their premiums are among the lowest of FEHBP plans.

On the one hand, critics of SA plans claim that such plans attract enrollees who cannot afford to spend more for health insurance premiums, but, because the plan might pay substantially less than the full charge for any given service, enrollees risk major out-of-pocket costs if they incur a large medical bill. On the other hand, including low premium/low benefit value plans in the program is viewed by some as the best way to make relatively inexpensive insurance available to enrollees who are at low risk, are infrequent users of health care, and who might otherwise go without insurance altogether. Also, unlike plans that use R&C limits on plan payments, SA plans list their payment limits for most medical procedures in their brochures. Thus, enrollees know in advance what the plan's payment limits are. It is also possible that an enrollee's out-of-pocket expenses for costs in excess of a plan's SA limits may not be substantially greater than the out-of-pocket expenses an enrollee would pay for coinsurance and charges in excess of an R&C limit. Further, like typical FFS plans, SA plans provide catastrophic expense protection if major costs are incurred.

2. *Comparison of FEHBP Fee-for-Service Plan Values*

The comparative benefit values of the 30 FFS plans currently offered under FEHBP can be determined by standardizing the population enrolled and using the FEHBP Model to compute a premium (exclusive of administrative costs). The standardized population includes all 1989 FEHBP enrollees. Plan values calculated in this way represent only the differences in covered services and the extent of enrollee cost sharing in each plan. Table 4.3 ranks the benefit values of FEHBP plans, including the lowest, the median and the highest for Self Only and Family coverage. For comparison, the table includes actual premiums computed to reflect the health care use of the different enrolled groups. (The plans ranked low, median and high for standard values do not necessarily rank in those same positions for actual premiums.)

TABLE 4.3. Comparison of FEHBP FFS Plan Values and Premiums, 1989

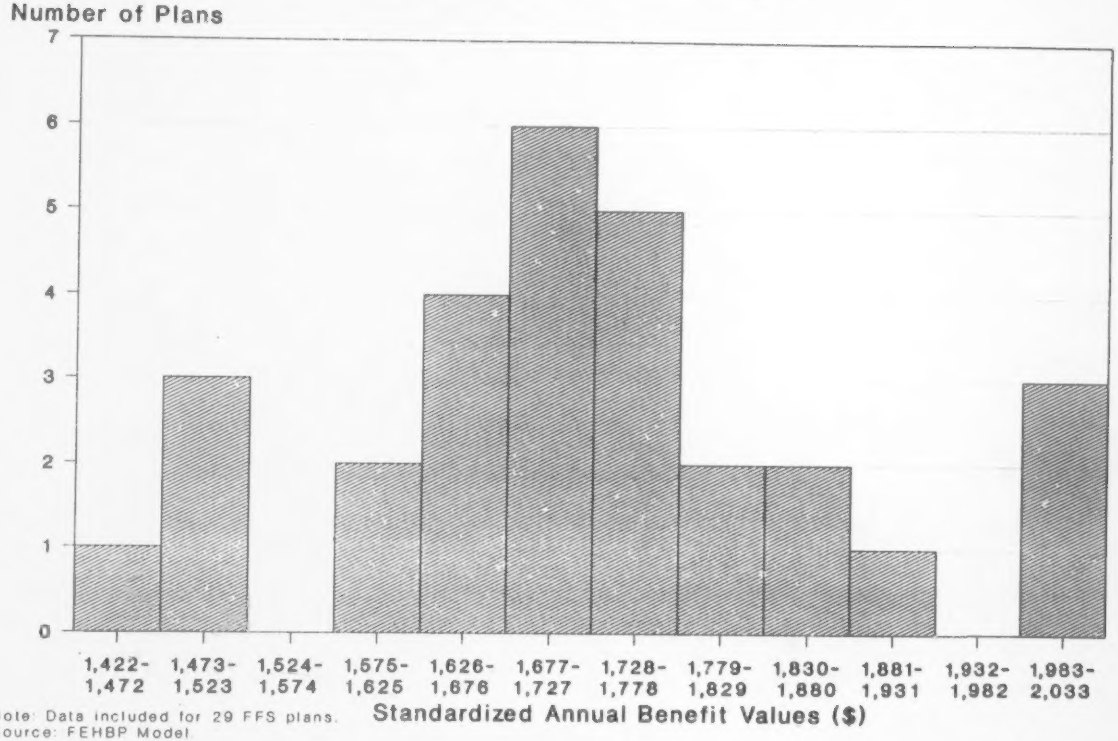
	Self Only coverage		Family coverage	
	Standard value	Actual premium	Standard value	Actual premium
Low	$1,422	$ 833	$2,908	$2,307
Median	$1,700	$1,502	$3,625	$3,347
High	$2,016	$3,032	$4,536	$6,400
range, high/low	+42%	+264%	+56%	+177%

Source: FEHBP Model.

The data show that the range in standard benefit values is considerably narrower than the range of actual premiums. This difference between benefit values and premiums illustrates how the characteristics of the enrollees in the different plans affect premiums. Holding the enrolled group constant, the benefit package of the most generous plan is "worth" 42 percent more than the least generous plan for Self Only coverage, and 56 percent more for Family coverage. However, the actual premium of the most expensive plan is 264 percent higher than the least expensive plan for Self Only coverage and 177 percent higher for Family coverage. Thus, comparison of actual FEHBP premiums alone would imply that there are extremely large differences among the benefit values of the plans, but when benefit values are compared *for a comparable population* it is demonstrated that, although there are significant differences in plan values, the variation is smaller than the premium differences indicate. In addition, these standardized plan values demonstrate how "risk selection," or pooling of high users of health care into certain plans, increases the premiums of those plans.

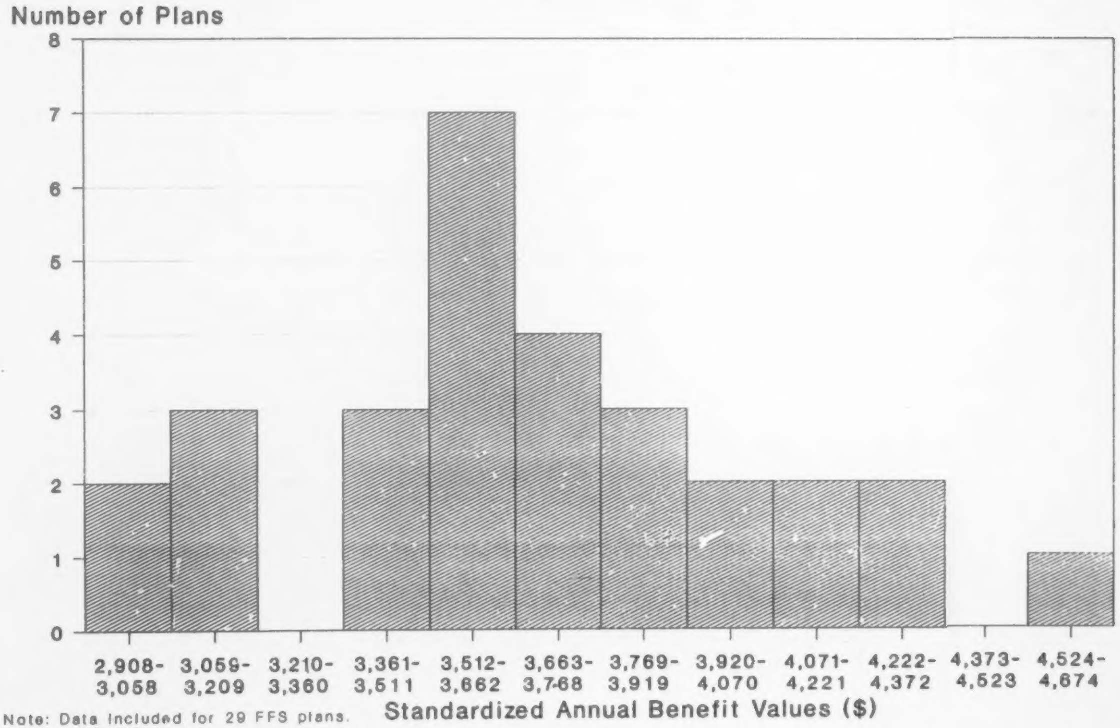
Although the range of standardized benefit values among FEHBP FFS plans is reasonably wide at the extremes (42 percent for Self Only coverage and 56 percent for Family coverage), most of the plans cluster around the center of the distribution, as illustrated in Figures 4.7 (Self Only coverage) and 4.8 (Family coverage). Half of FEHBP FFS plans fall within about a 10 percent benefit value range. This does not mean that they offer identical plan features, but the package of features they include is similar in value. Also, given the clustering of benefit features among FEHBP FFS plans discussed earlier in this chapter, clustering of plan values is to be expected.

Figure 4.7. Distribution of FEHBP Standardized Benefit Values (Self Only Coverage)



Note: Data included for 29 FFS plans.
Source: FEHBP Model.

Figure 4.8. Distribution of FEHBP Standardized Benefit Values (Family Coverage)



Note: Data included for 29 FFS plans.
Source: FEHBP Model.

E. How Alternative Plan Features Affect Plan Premiums

To evaluate the relative effect different plan features have on FEHBP plan premiums, a composite or "typical" FEHBP plan was constructed and applied to the standardized FEHBP population. The features of this typical plan are summarized in table 4.4. While it is not an actual plan, the benefit features of this typical plan generally represent the mode of the distribution of each feature among FEHBP FFS plans, with adjustments made to ensure that the combination of features is representative of those typically combined in a plan. Construction of this typical plan with an enrolled group representing all FEHPB participants allows a "value" or cost to be calculated in the FEHBP Model that is independent of the characteristics of the plan enrollees and that allows the cost effects of changing certain plan features to be estimated. If the characteristics of the enrolled group were different from the total FEHBP population, if the plan covered a population that was disproportionately old or disproportionately young, the effects of changes in plan features would be different.

The total premium for this typical FEHBP plan (exclusive of administrative costs) would cost $1,790 per year for Self Only coverage and $3,751 for Family coverage. If any of the plan features were changed, the cost of the premium would change. In order to estimate the sensitivity of the premium to changes in certain plan features, the FEHBP Model was used to hold constant all but one plan feature at a time, thereby illustrating the effect that changing individual features would have on plan costs. Some of the changes that were tested increased the generosity of the plan and raised the cost of the premium; others decreased the generosity of the plan and reduced the premium. Table 4.5 summarizes the effects of certain changes. (It should be pointed out that if more than one change were made simultaneously, the effect would not necessarily be additive because of the interactions among plan features.)

Table 4.5 shows that if the plan paid all covered costs and there were no overall deductible or coinsurance, the premium for this plan would be 25.7 percent higher. If there were no deductible and the only enrollee cost sharing were the coinsurance requirement, costs would be 13.8 percent higher. Adding expanded dental coverage (such as that included in the typical private plan) would increase premiums by 9.2 percent.

On the other side, a premium reduction of 3.3 percent could be achieved by raising the general deductible to $500; imposing a hospital admission deductible of $250 would save 2.7 percent. A 7.9 percent premium reduction could be realized if nonphysician hospital charges (room and board and other miscellaneous charges) were subject to enrollee coinsurance of 20 percent. Although only about 10 percent of the participating population is hospitalized during a year, the fact that overall premiums could be reduced by 7.9 percent if those people were required to pay 20 percent of their nonphysician hospital charges indicates how extraordinarily costly inpatient care is. It also shows the substantial value of 100 percent coverage of hospital charges and indicates that, without that coverage, those few people who are hospitalized would face large hospital bills even if they were required to pay only 20 percent of those bills.

Appreciable savings could be achieved by excluding coverage of dental care altogether or by not covering prescription drugs. Some contend that routine dental care is not appropriately an insurable service since it is care all people use and can be budgeted.

Finally, dropping coverage of well-baby care from the plan would save a small amount, less than one percent of premium costs. Routine care for infants and young children is costly and is valuable coverage for young families. However, it is used by a small portion of FEHBP enrollees and therefore, when the costs are spread over the enrolled group, covering well-baby care adds little to overall premiums.

TABLE 4.4. Features of a Typical FEHBP Plan

Benefit	Plan provision
Overall deductible (per person/family maximum)	$250/$500
Annual out-of-pocket limit	$1,500/$2,500
Lifetime maximum	none
Hospital services:	
Room and board, 365 day per stay maximum	100%
Other hospital expenses	100%
Hospitalization alternatives	100%
Surgical services	80%
Physician services (nonsurgical)	80%
Diagnostic tests	80%
Prescription drugs	80%
Mental health care:	
Inpatient care (annual 30-day maximum for room and board)	80%
Deductible (per person/per admission)	$500
Annual out-of-pocket limit	$8,000
Lifetime maximum	$50,000
Outpatient care (annual 50-visit maximum)	50%

TABLE 4.4. Features of a Typical FEHBP Plan
--Continued--

Benefit	Plan provision
Dental care:	
Routine/basic	scheduled amount
Restorative/reconstructive	none
Other services:	
Emergency/accidental injury	100%
Well-baby care	Yes[a]
Routine physical exams	none

[a] May be subject to limitations on number of visits and covered charges.

Source: FEHB Team, based on OPM plan brochures for 1988 open season.

TABLE 4.5. Sensitivity of FEHBP Plan Premium to Changes in Typical Plan Features (individual coverage)

Features increasing premiums		Features decreasing premiums	
Plan feature/percent increase[a]		Plan feature/percent decrease	
Remove all deductibles and enrollee coinsurance	+25.7%	Raise general deductible to $500	-3.3%
Remove all deductibles (retain coinsurance)	+13.8	Adopt a $250 hospital admission deductible	-2.7
Reduce general deductible to $100	+5.8	Require 20% enrollee coinsurance for hospital board and room and miscellaneous charges	-7.9
Eliminate enrollee coinsurance requirements (retain deductibles)	+8.2	Eliminate all dental coverage	-4.1
Add full vision care	+2.3	Eliminate prescription drug coverage	-4.7
Adopt typical private plan dental coverage	+9.2	Eliminate mental health and substance abuse coverage	-1.7
		Eliminate well-baby care	-0.6

[a] The increases and decreases are computed using the premium cost for Self Only coverage under the typical FEHBP plan ($1,790) as the base. (Well-baby care was estimated for Family coverage.)

Source: FEHBP Model.

CHAPTER 5. COMPARABILITY OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM WITH NONFEDERAL PRACTICE

The Federal Government operates, through its Office of Personnel Management (OPM), the Nation's largest employer-based health insurance program. FEHBP differs from the plans of large nonfederal employers in the level and manner of coverage. Further, OPM does less than most large nonfederal programs to institute program-wide cost control mechanisms, and it gives employees much greater freedom of choice in selecting plans.

This chapter compares FEHBP with health benefits and related employee compensation in the nonfederal sector. Section A compares the value of health benefits that are typically offered by private sector employers with those available under FEHBP and discusses State and local government practice. Section B examines innovative approaches undertaken by some employers to provide employee health benefits, mainly to lower health insurance costs. Section C describes how employers are incorporating health benefits into "flexible" benefit packages that allow employees to make tradeoffs among health and other benefits. Section D briefly describes the health benefit plans of 13 major private and public employers. Section E compares the relative value of health benefits to total employee compensation for Federal and private sector workers.[23]

In examining Federal versus nonfederal sector practice, the FEHB Team found that:

- If health benefits typically offered by large private firms were made available to the population of Federal workers and retirees, their value (total cost) would exceed that of benefits in the "typical" FEHBP plan by 15 percent for Self Only coverage and 16 percent for Family coverage.

- The private sector, as represented by the "typical" private sector plan, pays the full cost of employees' and 75 percent of dependents' premiums, while the Federal Government, if it adopted the "typical" FEHBP plan, would pay in 1989 about 73 percent for both employee and dependent coverage for nonpostal employees under the existing FEHBP contribution formula.

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[23] See also chapters 6, 7, and 9 for a comparison of certain aspects of FEHBP health benefit plans with those in the private sector. Chapter 6 discusses the degree of choice available to in FEHBP and private sector health plans. Chapter 7 discusses how private sector employers cover retirees under their health benefit programs. Chapter 9 analyzes what it would cost the Federal Government to adopt the premium-sharing practices of private firms.

- In continuing efforts to contain health care costs, many private firms are exerting greater management control over their health benefit plans and increasing their leverage with providers.

- Increasing numbers of nonfederal employers are incorporating health benefits into "flexible benefit" or "cafeteria" plans, which allow employees to tailor the total benefit package to meet individual needs.

- Overall, the relative value of total employee compensation (benefits, including health benefits, and wages) in the private sector exceeds that available to Federal workers. However, nonwage compensation is higher for Federal personnel, reflecting a relatively generous retirement system.

- The detailed examination in section D of the health plans of 13 major employers identified several significant trends: (1) these plans tend to be insured and managed by the employers; (2) in most cases, strong financial incentives favor PPOs and HMOs over traditional FFS arrangements; (3) FFS options are few in number but are structured to give employees a wide range of choices with respect to the degree that their health care expenses are covered; (4) premiums for Self Only coverage are mostly employer-paid; (5) premiums for Family coverage are specified for several different family types, and tied to salary in a few cases; and (6) election of a low-cost health plan gives employees options to elect other fringe benefits or additional cash pay in many cases.

A. Comparison of FEHBP and Nonfederal Health Benefit Packages

The health plans typically available to employees of large private sector firms, while similar in some respects to plans typically found in FEHBP, embody some important differences. Overall, the private sector's total health benefit package is usually more generous than that available to Federal employees, particularly with respect to the share of the premium paid by the employer, deductible amounts, and dental coverage. On the other hand, nonfederal plans offer employees fewer choices among plans. This section compares the value of FEHBP benefits with those offered by private firms by comparing a "typical" FEHBP FFS plan with a "typical" private sector FFS plan.[24] (See table 5.1 for a comparison of the benefits under both typical plans.) It also compares Federal and private sector differences in premium sharing. Finally, it examines the health benefit plans available to State and local government employees.

The FEHBP/private sector comparison does not include a comparison of HMOs for two reasons. One, although HMOs have become more widespread, fewer than one-fourth of FEHBP enrollees and one-fifth of employees in large private firms are in such plans. Two, there is more variation among FFS plans than among HMOs, all of which generally offer comprehensive benefits.

1. ***Health Benefit Plans: FEHBP vs. Private Sector***

a. *Benefit features of FEHBP and private sector plans.*

(1) Overall deductible. Overall deductibles are $250 per person ($500 family maximum) for the typical FEHBP plan and $100 per person ($300 family maximum) for the typical private sector plan. Because of the rather large difference in deductibles between the FEHBP plan and the private sector plan, individuals and families with similar medical bills would have lower out-of-pocket costs under the private plan. Two-person families with similar medical bills would have the greatest difference ($300) in the out-of-pocket costs they would have to incur before the plan paid for covered services. Under the FEHBP plan, a two-person family would have to meet two deductibles of $250 per person ($500), but under the private sector plan would have to meet two deductibles of $100 per person ($200), a difference of $300.

(2) Annual out-of-pocket limit. The annual out-of-pocket limit for the typical FEHBP plan caps out-of-pocket spending for coinsurance requirements at $1,500 per person and $2,500 per family, compared with $1,000 per person and $2,000 per family under the typical private sector plan.

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[24] For purposes of comparison, CRS and Hay/Huggins Company, Inc. developed composite FFS health plans representing "typical" private sector and FEHBP practice. The "typical" private sector plan incorporates benefit features most commonly found among medium and large firms and is based on data in the *1988 Hay/Huggins Benefit Report (HHBR)*. Similarly, the "typical" FEHBP plan incorporates the most common benefit features of the FFS plans available under FEHBP in 1989. It should be emphasized that the "typical" plans are composites incorporating the most common plan features and that the combination of these features may not produce a plan found in actual practice. Also, the range of choice offered in FEHBP means that it is likely that an enrollee can find a plan with some features found in the "typical" private sector plan, for example, a lower deductible.

CRS and Hay/Huggins also examined data available from the Bureau of Labor Statistics (BLS) and found that a typical State/local plan would be nearly identical in both benefits and value to the typical private sector plan.

(Neither plan counts the overall deductible toward such limits.) Thus an individual under the typical FEHBP plan must have a medical bill for nonhospital costs of $7,750 (the $250 deductible, plus the 20 percent coinsurance on the remaining $7,500, or $1,500) before the plan would pay all covered charges. The typical private sector plan would pay all covered charges after the enrollee incurred a bill of $5,100 (the $100 deductible, plus 20 percent coinsurance on $5,000, or $1,000).

(3) Lifetime maximum. Neither the typical FEHBP nor the typical private sector plan has a lifetime maximum to limit the amount the insured will be reimbursed for medical expenses over a lifetime.

(4) Covered services.

(a) Hospital, surgical, and other services. FEHBP and the private sector, as represented by the "typical" plans, provide identical coverage for most hospital, surgical, and other expenses. As shown in table 5.1, both plans pay 100 percent of semiprivate room hospital charges, for 365 days per stay, 100 percent of emergency care for accidental injury, and 80 percent of reasonable and customary charges for inpatient and outpatient care by physicians, including surgeons, X-rays and laboratory work, and prescription drugs. However, FEHBP covers well-baby care while the private sector plan does not. Neither FEHBP nor the private sector plan cover routine physical examinations or vision care.

(b) Mental health care. Mental health care is covered by both plans. It is common practice for health plans to apply cost sharing and coverage limitations for mental health care that differ significantly from those the plan applies to nonmental health care, as this is the case for the typical FEHBP and private sector plans. Both typical plans pay 80 percent of charges for inpatient mental health care for a maximum of 30 days and 50 percent of charges for outpatient mental health care with a maximum of 50 visits per year.

Overall, the mental health care features of the two typical plans balance their coverage and limits differently. The typical FEHBP plan requires a separate inpatient mental health deductible of $500 and limits annual out-of-pocket expenses for inpatient care to $8,000. Lifetime payments for inpatient care are capped at $50,000 under the FEHBP plan, but an enrollee who has used up the maximum coverage can switch plans during open season and start coverage with a new plan. In contrast, the private sector plan requires no separate inpatient mental health deductible, has no lifetime maximum, but does not limit an enrollee's annual out-of-pocket expenses for inpatient mental health care. These differences in mental health coverage tend to offset each other and do not account for a significant difference in the costs of the two plans.

(c) Dental care. The typical FEHBP plan provides routine dental care (prophylaxis) and basic care (fillings), paying a scheduled allowance per service. The typical private sector plan provides more generous coverage,

paying 80 to 100 percent for these routine and basic services. In addition, the private plan covers a number of restorative and reconstructive procedures not included in the FEHBP plan, such as root canals, treatment of gum disease, crowns and inlays, and dentures.

(5) Cost containment. To contain costs by reducing unnecessary or inappropriate surgery and hospitalization, both the FEHBP and private sector plans require enrollees to obtain second opinions for certain surgical procedures and prehospitalization certification.[25]

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[25] Although the typical FEHBP and private sector plans both incorporate the same cost containment features, it should be noted that it is thought that, overall, private sector employers generally exert greater management control to contain health insurance costs than does OPM.

TABLE 5.1. Comparison of Benefits Under Typical FEHBP and Typical Private Employer Plans, 1989[a]

	Plan provision	
Benefit	FEHBP	Private
Overall deductible[b] (per person/family maximum)	$250/500	$100/300
Annual out-of-pocket limit[c] (per person/family maximum)	$1,500/2,500	$1,000/2,000
Lifetime maximum	None	None[d]
Hospital services		
Room and board, 365-day per stay maximum	100%	100%
Other hospital expenses	100%	100%
Hospitalization alternatives (extended care[e] or home health care)	Yes	Yes
Surgical services	80%	80%
Physician services (nonsurgical)	80%	80%
X-rays and laboratory work	80%	80%
Prescription drugs	80%	80%
Emergency/accidental injury	100%	100%

See footnotes at end of table.

TABLE 5.1. Comparison of Benefits Under Typical FEHBP and Typical Private Employer Plans, 1989[a] --Continued--

	Plan provision	
Benefit	FEHBP	Private
Well-baby care	Yes[f]	None
Routine physical exams	None	None
Mental health care		
Inpatient care (annual 30-day maximum for room and board)	80%	80%
Separate deductible (per person/ per admission)	$500	None
Separate annual out-of-pocket limit	$8,000	None
Separate lifetime maximum	$50,000	None
Outpatient care (annual 50-visit maximum)	50%	50%
Dental care		
Routine	scheduled amount	100%
Basic	scheduled amount	80%
Restorative/ reconstructive	None	50%

TABLE 5.1. Comparison of Benefits Under Typical FEHBP and Typical Private Employer Plans --Continued--

Benefit	Plan provision FEHBP	 Private
Cost containment features		
Mandatory second opinion for selected surgical procedures	Yes	Yes
Prehospitalization certification	Yes	Yes

[a] Percentages are percent of reasonable and customary rates for covered services paid by the plan, except for hospital room and board, which the plans pay as a percentage of the hospital's semiprivate room rate.

[b] Overall deductible generally applies to surgical and physician services, X-rays and laboratory work, prescription drugs, and outpatient mental health services.

[c] Under both plans, out-of-pocket costs counted toward the limit include coinsurance for surgical and physician services, X-rays and laboratory work, and prescription drugs. Overall deductibles are not counted.

[d] While most plans place a limit on the amount of medical expenses they will pay, it is usually set at $1 million or more. Thus, for all practical purposes, there is no lifetime maximum.

[e] Extended care is 24-hour skilled nursing care, in lieu of hospitalization.

[f] Subject to certain limits, such as limits on the number of visits and payment per visit.

b. Value of the typical FEHBP and private sector benefits. The private sector plan has additional coverage not found in the FEHBP plan, and this is reflected in the difference in costs of the two plans. If offered to the standard Federal employee and annuitant population in 1989, the benefit value[26] (total cost) of the private sector plan would exceed that of the typical

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[26] As estimated using the FEHBP Model. Benefit values are the estimated annual premiums for the two plans if offered to the same population (in this case, the Federal employee and annuitant population). Any difference in value can be attributed to differences in benefits.

FEHBP plan by 15 percent for Self Only coverage and by 16 percent for Family coverage. For Self Only coverage, 1989 benefit values would be $1,790 for the typical FEHBP plan and $2,054 for the typical private sector plan. For Family coverage, the values would be $3,751 for the typical FEHBP plan and $4,355 for the typical private sector plan. The additional value of the private sector plan, $264 for Self Only and $604 for Family, is attributable mostly to the following:

- *Overall deductible.* A lower overall deductible found in the private sector plan accounts for about 35 percent of the difference in the cost of the two plans for both Self Only and Family coverage.

- *Additional dental benefits.* The FEHBP plan pays for only part of the charges for routine and basic dental care (e.g., prophylaxis and fillings), but the private sector plan provides broader dental coverage on more generous terms. This additional coverage accounts for about 58 percent of the difference in the cost of the two plans for both Self Only and Family coverage. About one-third of the cost of this additional coverage is for higher payments for prophylaxis and fillings.

- *Annual out-of-pocket limit.* About 6 percent of the difference in the costs between the two plans is attributable to the lower annual out-of-pocket limit in the private sector plan.

Although the typical private sector plan has more generous benefits than the typical FEHBP plan, it should be noted that covering the Federal employee and annuitant population with the typical private sector plan would cost about 22 percent more for Self Only and 18 percent for Family coverage than it would in the private sector in 1989. For Self Only coverage, the private sector plan would cost $1,678 if offered to the private sector workforce but $2,054 if offered to the standard Federal employee and annuitant population. For Family coverage, the private sector plan would cost $3,700 for the private sector population but $4,355 for the Federal population. The difference in costs to insure the two groups is largely attributable to the inclusion of annuitants in the FEHBP population. The FEHBP population includes retirees, but the private sector population does not. Private employers typically cover retirees in a group separate from their workers. Thus, even if the benefit package offered private sector retirees were the same as that offered to the firm's workers, the premiums would be calculated separately. However, private sector employers who offer health insurance to retirees usually do so under a different benefit package which takes Medicare's coverage into account.

2. *Employer Share of Premium: FEHBP vs. Private Sector*

While the benefits covered under the health insurance plans of the Federal and private sectors are similar, differing mostly with respect to the overall deductible amount and dental coverage, there are large differences between the Federal Government and private firms in the share of the

premium they pay and, consequently, in the residual share paid by the worker. This difference in the employer-employee share of the premium significantly affects the overall value (cost) of a health benefits package to an employee. For example, if the Federal Government adopted the typical FEHBP plan, which in 1989 would cost $1,790 for Self Only coverage and $3,751 for Family coverage, the Government's share for nonpostal employees under the existing FEHBP contribution formula would be about 73 percent for both Self Only and Family coverage. Employees would pay the remaining 27 percent, or $483 for Self Only and $1,001 for Family coverage. If the Federal Government adopted the typical private sector plan, which in 1989 would cost $2,054 for Self Only and $4,355 for Family coverage, the Government's share for nonpostal employees would be about 64 percent for Self Only and 63 percent for Family coverage. Employees would pay the remaining 36 percent and 37 percent for Self Only and Family, respectively, or $748 and $1,605.[27]

Such employee costs under FEHBP differ from typical private sector practice, which pays employees' full premium cost for Self Only coverage. While the private sector premium-sharing practice for Self Only coverage exceeds that of FEHBP, Hay/Huggins reports that, in an effort to reduce their costs of financing employee health plans, employers may be moving away from this practice and shifting some of the cost of the premium onto employees. In 1975, 62 percent of the firms surveyed by Hay/Huggins paid the full premium cost of employee health coverage, compared to 57 percent in 1988. For coverage of employees' families, there is less difference between the Federal and private sector in the employer-employee share of the cost of the premium than for Self Only coverage. Typical private sector practice, as represented by the typical private sector plan, pays 75 percent of the premium cost for Family coverage compared to the Federal Government's contribution of about 73 percent for Family coverage if it adopted the typical FEHBP plan.

3. State and Local Government Health Benefit Plans

In 1987, health care benefits were provided to 94 percent of State and local government employees. About one out of three shared in premium costs for Self Only coverage. The plans available to 70 percent of employees required employee premium contributions for Family coverage. This section briefly discusses the health care coverage available to such workers and State and local government premium-sharing practices.[28]

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[27] The employee share under the typical private sector plan is higher than under the typical FEHBP plan because the existing FEHBP contribution formula limits the dollar amount the Government contributes, thereby resulting in a higher employee share for certain higher costs plans.

[28] This section is based on data found in: U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in State and Local Governments, 1987*. Washington, 1988, and unpublished BLS tabulations. The BLS data includes data on HMOs and PPOs as well as FFS plans.

a. Benefit features of health plans available to State and local government employees.

(1) Overall deductible. Almost half of State and local government employees were in plans which required an overall deductible similar to that of the typical private sector plan, $100 per person ($300 family maximum.) An additional 28 percent were in plans requiring a deductible larger than $100 but no more than $200 per person.

(2) Annual out-of-pocket limit. Limits on annual out-of-pocket expenses were often lower for State and local government employees than for FEHBP enrollees, as represented by the typical FEHBP plan. About two-thirds of State and local employees were in plans with out-of-pocket expenses (excluding the deductible) limited to $1,000 or less per person with no family maximum.

(3) Lifetime maximum. As with the typical FEHBP and private sector plans, which do not have lifetime maximums limiting reimbursement for medical expenses over a lifetime, State and local government employees were in plans with lifetime maximums of $1 million, which provide virtually unlimited reimbursement over a lifetime.

(4) Covered services.

(a) Hospital, surgical, and other services. State and local government employees were covered for the same categories of medical care services as Federal and private sector workers. In 1987, virtually all State and local government employees with health benefits were in plans that covered them for hospitalization, care by physicians and surgeons, X-rays and laboratory work, and prescription drugs. However, well-baby care, routine physical examinations, and vision care were not widely available, with less than 37 percent of State and local government employees in plans with such coverage.

Except for surgical expenses, which were often reimbursed in full, health plans for State and local government employees generally paid the same coinsurance rates for medical services as the typical FEHBP and private sector plans. Hospitalization was generally paid at the full semiprivate room rate, or at least at the full rate for a specified period of time after which a percentage (usually 80 percent) was paid. According to BLS, about two-thirds of employees were in such plans. One-half of employees were in plans where inpatient and outpatient surgical benefits were reimbursed in full. For other medical expenses (physician services, X-rays and laboratory tests, and prescription drugs), over three-fourths of employees were in plans that paid 80 percent of these expenses.

(b) Mental health care. Inpatient and outpatient mental health care was covered for 98 percent of State and local government employees with health plans. Limitations on mental health care coverage were similar to the typical FEHBP and private sector plans. According to BLS, inpatient care

was generally covered at 80 percent of expenses for 30 days and outpatient care at 50 percent for an annual maximum of 50 visits.

(c) Dental care. Sixty-two percent of State and local government employees were covered for dental care. Dental coverage for such workers is comparable to the typical private sector plan, which provides more generous coverage than FEHBP. Nearly all plans covered a full array of dental services, including routine care, fillings, oral surgery, treatment of gum disease, crowns and inlays, root canals, bridges, and dentures. Routine care was generally covered at 100 percent; fillings, oral surgery, treatment of gum disease, and root canals at 80 percent; and crowns, inlays, bridges, and dentures at 50 percent. About one-half of employees were required to pay an annual dental deductible, generally averaging $55, and three-fourths were limited to a yearly maximum of $1,000 in dental benefits.

(5) Cost containment. While some State and local government employees were in plans with cost containment features, such as incentives to obtain second opinions for certain surgical procedures and prehospitalization certification, such features are not as widespread as in FEHBP and private sector plans, as represented by the typical plans. Almost one-fourth of State and local government employees were in plans with incentives to obtain second surgical opinions. About one-fifth were in plans requiring prehospitalization certification.

b. Employer share of the premium. As with the typical private sector plan, many State and local governments paid the full cost of health benefit plans for Self Only coverage. According to BLS, 65 percent of State and local government workers had individual coverage wholly financed by their employers in 1987. Martin E. Segal, Co. found that about two-thirds of the States paid 100 percent of the cost for Self Only coverage in 1988.[29]

For Family coverage, State and local governments generally paid only a portion of the cost. In 1987, BLS reported that 71 percent of State and local government employees were in plans that required sharing in the cost of Family coverage. Martin E. Segal, Co. found that about 45 percent of States paid between 60 and 99 percent of the cost of Family coverage in 1988.

B. Innovative Approaches in Provision of Employee Health Benefits

Employers are changing the health insurance coverage they provide employees in a variety of ways, mainly to lower health plan costs. Many employers have sought to stabilize the cost of their employee health benefit plans in recent years. The more prevalent cost containment measures include: cost shifting to employees through higher deductibles and premium cost sharing; alternative financing arrangements, such as self insurance and third-party administration; incentives to use alternative services such as home health care; and managed care.[30]

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[29] Martin E. Segal, Co. *State Employee Health Benefit Plans, 1988.* New York, 1988.

However, as health plan costs continue to rise, some employers are changing the health insurance coverage they provide employees in a variety of ways. These efforts can be grouped as follows: (1) changes in the procurement of health services; (2) improvements in utilization control measures; (3) incentives for modified consumer behavior by employees; and (4) reforms in coverage of specific groups. However, in contrast to these cost containment efforts, there also are signs that coverage is being *extended* in one new benefit area--long-term care.

This section describes a range of employer innovations.[31] They are presented uncritically to inform the reader about recent changes nonfederal employers have made in their health plans. This presentation should not be taken to imply that these innovations could, or should, be adopted by FEHBP.

1. *Procurement of Services*

Some employers have begun negotiating directly with health care providers for some or all of the services available to their employees. These employers believe that they can obtain care at a lower cost by selecting efficient providers and bargaining directly with them. An example is a consortium of San Francisco Bay area firms (Hewlett-Packard, Lockheed, Apple Computer, TRW, and Xidex), which have contracted directly with an area hospital to provide services to their employees at negotiated rates. Another example is San Bernardino County, California,[32] which dropped its insurance carriers and now deals directly with local providers for covered services for county employees.

Employers are also improving their leverage in negotiating HMO contracts. Pacific Telesis[33] found adverse selection to be a problem in migration between its FFS and HMO plans. Steps were taken to improve information on HMO costs and utilization in order to negotiate a capitation fee more in line with actual experience. Allied-Signal[34] has negotiated an

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[30] These cost control features, including those used in FEHBP, are discussed in chapter 4.

[31] Examples of employer innovations have been drawn from numerous issues of the following publications: *Business and Health*, *Business Insurance*, *BNA Pension Reporter*, *Employee Benefit Plan Review*, and *USA Today*.

[32] This employer plan is described further in section D of this chapter.

[33] Ibid.

[34] Ibid.

HMO arrangement with CIGNA that sets a limit on cost increases the firm will incur over the 3-year contract. In return, Allied-Signal agreed to redesign its overall health plan to create strong financial incentives for its employees to enroll in the HMO rather than in the FFS plan.

Employers are also trying to coordinate their health plan options more effectively. A group of Maryland employers has established a relationship with a network of health plans that includes HMOs. All plans in the network provide standard benefits, and employees are charged a single price that reflects the average cost of the plans. Thus, employees base their choice solely on convenience and perceived quality of care.

One employer, GTE, has singled out a particular benefit--mental health--for a different approach aimed at reducing its cost. GTE has contracted with a mental health PPO, though retaining a standard FFS approach for other covered services, in order to obtain mental health services for employees at lower rates. Genentech, concerned about heavy use of mental health services, offered its employees five free counseling sessions outside its FFS plan with psychologists selected by the firm and succeeded in lowering utilization. In another case, General Motors[35] went to a separate carrier for the provision of substance abuse services to its employees in order to obtain better control over these services than it had under its FFS plans.

2. *Improved Utilization Control*

Cost containment measures such as second opinion requirements, case management, and precertification of hospital admissions have become commonplace among private employers. At RCA, an effort has been made to integrate these features with claims processing to enhance control and efficiency and thereby avoid raising the employees' share of costs. Honeywell has used its on-site occupational health nurses as "health service advisers" who identify high-cost cases and monitor their treatment. The intent is to both improve case management and communicate the value of such management to employees.

3. *Incentives to Change Employee Behavior*

Some employers seek to change employee use of health care services by providing employees with better information on physicians and hospitals. Ryder System, Inc. has set up a computer data bank for its employees that gives qualification information (e.g., degrees, board memberships) and fee data on physicians and hospitals in the area. Employees may use the data bank to find specific types of providers, their locations, and how much the fee will be for a particular procedure. The data bank shows that high fees are not directly correlated with provider credentials and experience. It is anticipated that employees will use this tool to obtain health care at lower cost. In another case, a small manufacturer (Nordskog) collected physician fee data and barred reimbursement for physicians who were judged to charge its employees excessive fees.

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[35] Ibid.

Health promotion and wellness programs have been established at a growing number of private firms. About two-thirds of private worksites with 50 or more employees support at least one health promotion activity, according to a recent survey. The 1986 Wyatt survey of large employers found that half had some type of health promotion plan. These programs often include nutrition education, physical fitness activities, counseling on smoking cessation, stress management education, and safety lectures. Leaders in this development include Southwestern Bell, Apple Computer, Bank of America, Chevron, Levi-Strauss, and Xerox.[36]

Health promotion programs are popular among employers for several reasons: they improve employee morale and may enhance employee well-being and increase the productivity of the workforce. However, evaluations of health promotion programs indicate that real reductions in health plan costs may be more difficult to achieve than anticipated. Studies showing positive effects of these programs often fail to account for health factors that may be associated with those who self-select to participate. Also, the studies generally do not provide data on effects for more than a short time period. Furthermore, the cost-effectiveness of health promotion plans may be undermined because persons with low health risks often are as likely to participate as are the high-risk employees.

To attract more employees into HMOs, some employers are now offering a "free-ranging" or "open-ended" HMO that permits enrollees to obtain services outside the HMO. Such outside care incurs higher copayments, but this flexibility for the consumer makes the HMO more desirable.

Firms are also designing plans that encourage employees to use alternate care facilities (ACFs) in lieu of more expensive hospital rooms. This encouragement is provided by compensating for ACFs at a higher rate than for hospitalization. For example, a plan with a deductible for hospitalization might exempt a visit to a surgicenter from the deductible.

Some firms (e.g., Southland Corporation) have arranged an option by which covered employees may obtain prescription drugs by mail. The health plan's costs for drugs are determined by wholesale prices, and the plan also benefits from economies of scale. Employees benefit by the elimination of claim filing, the need for less frequent refills of long-term maintenance drugs, and the convenience of direct delivery to the home. This service is appropriate only for persons undergoing drug therapy for chronic problems. Many FEHBP FFS plans also have mail order prescription drug programs.

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[36] Ibid.

4. *Coverage Reforms*

One way to reduce the cost of health care coverage is to limit coverage for certain population groups. For example, J.C. Penney extends coverage to its employees' spouses only if the spouse has less wage income than the Penney employee. A spouse with higher wages is expected to obtain health coverage through his/her employer.[37]

Employers are also modifying the way in which premiums are structured by family composition to reduce subsidization of some family types by others. Traditionally, premiums have been set for Self Only coverage and for Family coverage. Some plans (the State of Kansas employee plan, for example) now have multiple premium levels to distinguish several types of Family coverage (such as childless couples, one adult with children, two adults with children).

Employers are also interested in reducing their financial responsibility for retiree health benefits. Three States have adopted new provisions for their retired public employees. Wisconsin now requires its State agencies to prefund retiree health benefits. Retirees may credit unused sick leave against premium charges. The State is considering a years-of-service criterion to determine coverage. Colorado and Texas have adopted similar measures.

5. *Long-Term Care Insurance*

There is growing recognition that the potentially catastrophic expense of long-term care is the major gap in existing insurance arrangements. Few employers have offered such insurance. However, some employers have recently begun to offer long-term care coverage to their employees, including Aetna, Travelers Insurance, John Hancock Life Insurance, American Express, Proctor and Gamble, and the States of Alaska and Maryland.[38]

Such coverage is usually offered through a separate plan. Premiums are age-adjusted. Benefits are generally not related to inflation, so added protection must be obtained as the amount of coverage initially purchased loses its value over time. In Alaska's program, which is the oldest, 30 percent of eligible retirees have elected long-term care coverage.

C. Flexible Benefit Plans

A growing number of employers are changing the way in which health benefits are packaged with other employer benefits. They give an employee additional choices in selecting benefits so that an individual can tailor his/her own benefit package. Such benefit plans are called flexible benefit plans, or "cafeteria plans." (They are termed "flex plans" in the following discussion.)

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[37] Penney's policy was challenged unsuccessfully in court by the Equal Employment Opportunity Commission as sexually discriminatory.

[38] Ibid.

According to BLS, 5 percent of employees in medium and large firms were eligible for flex plans in 1988.[39]

1. *Statutory Requirements for Flex Plans*

Section 125 of the U.S. Internal Revenue Code governs the tax treatment of flex plans. Employees covered by plans that meet the requirements of section 125 may have out-of-pocket benefit costs treated as having come from before-tax wages through salary reductions. The value of employer-provided benefits is also tax-free.

To be considered a flex plan, a plan must include two or more benefits that are not taxable under the Internal Revenue Code, or at least one such benefit plus cash wages. Benefits often incorporated in a flex plan include health insurance, life insurance, disability insurance, paid leave, dependent care, and 401(k) retirement saving plans. Some benefits are statutorily prohibited from inclusion (transportation assistance, education assistance, employee discounts, scholarships). The plan must be a written agreement, and its coverage and participation must meet the section 89 nondiscrimination tests. These tests are designed to prevent plans from providing benefits to highly compensated employees that greatly exceed benefits for other employees.

2. *How Flexible Benefit Plans Work*

The benefits included in a flex plan may be conventional in nature (e.g., FFS health plans, group term life insurance), or they may be structured in the form of spending accounts. In the latter case, an account is established by the employer for the employee into which the employee contributes a certain amount of wages on a before-tax basis. The funds can be used only for a certain purpose, such as bona fide out-of-pocket health expenditures. Any balances remaining in the accounts at the end of the year revert to the employer. Flex plans may include both conventional benefit plans and spending accounts, or they may be restricted to one type of benefit arrangement.

Flex plans also differ with respect to the degree of employee choice and tradeoff involved. A plan could incorporate one or more health benefit plans, and each plan could allow a range of choices (e.g., in size of deductible). A health plan might or might not be accompanied by a health spending account. An employee might or might not be allowed to waive health coverage entirely; a waiver might allow all the employer's benefit dollars for that employee to be used for coverage by other parts of the flex plan. The tradeoff of health with other benefits can vary in the degree allowed, and a cash option can be included as well. That is, any unused employer benefit dollars can be received by the employee as additional taxable wages.

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[39] U.S. Department of Labor. Bureau of Labor Statistics. News release on 1988 BLS *Survey of Employee Benefits in Medium and Large Firms*. Apr. 4, 1989. p. 3.

Employers often apply a "defined contribution" philosophy to a flex plan's value. That is, the total value of the package is pegged to a percentage of compensation. When benefit costs rise from year to year, the employee will have to absorb any costs that rise faster than compensation, either by spending more out-of-pocket or by reducing consumption of the least necessary benefit. For example, if employees are given benefit credits set at a percentage of wages to allocate among available coverages, then the credits will buy less in benefits over time if premium costs rise faster than wages. However, excessively high inflation over a sustained period would pressure the employer to increase the defined contribution amount in order to avoid labor dissatisfaction with the plan.

Flex plans are becoming more common in the private sector. Foster Higgins[40] found that about one-third of firms with 1,000 or more employees have flex plans, up from 18 percent in 1987. A study of flex plans by Hay/Huggins[41] found that nearly half the plans studied were implemented since January 1, 1987. A Hewitt survey[42] found that medical and dental plans are the most common benefits included in flex plans, with flex plans offering an average of three health plan options.

Flex plans have also been adopted in State and local governments. About one in 11 State and local employees is covered by a flex plan.[43] Teachers are the public employees most often found to have flex arrangements (11 percent).

D. Descriptions of Selected Employer-Sponsored Health Benefit Plans

This section presents brief descriptions of 13 health benefit plans of large employers. The plans selected include eight corporate plans, two plans for local government employees, and three State employee plans. Except for the local governments, each employer provides coverage for employees at worksites scattered over large geographic areas.

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[40] A. Foster Higgins and Company, Inc. *A Survey of Flexible Benefits Programs.* New York, 1988.

[41] Hay/Huggins, Company, Inc. *1988 Hay/Huggins Flexible Benefits Report.* Philadelphia, 1989.

[42] Hewitt Associates. *Salaried Employee Benefits Provided by Major U.S. Employers in 1987.* Lincolnshire, Illinois, 1988.

[43] U.S. Department of Labor. *Employee Benefits in State and Local Governments, 1987.* Washington, U.S. Govt. Print. Off., May 1988.

The purpose of these descriptions is to show how various employers have dealt with the issues in plan design that face the Federal Government in its consideration of FEHBP reform. The plans chosen for this section were not randomly selected to represent a particular group of employers. Rather, they were chosen because each plan illustrates one or more approaches that a major employer has taken in recent years to handle issues of interest in analyzing FEHBP.

Certain plan design questions are addressed by all of these examples: the extent of plan choice, availability of HMOs, levels of deductibles and coinsurance, the structuring of premium charges by family type, and the party providing the insurance. Other questions are illuminated by the design of a specific plan. The following list indicates the specific design issues illustrated by particular employer plans:

- **Allied-Signal**--To control costs, the firm has designed its system to encourage employees to use CIGNA HMOs for their health care. In return, CIGNA has established a 3-year limit on cost increases for health services to the firm's employees.

- **Bell Atlantic**--The health plan is part of a flex plan. Enrollees elect benefit choices using a computerized information system that displays personal information about the financial impact of each choice.

- **General Electric (GE)**--GE has recently instituted enrollee sharing in premium cost, with the degree of cost sharing related to salary level. A hospital review program has been established to monitor hospitalization from preadmission approval to discharge planning.

- **General Motors (GM)**--The firm's FFS plan was once administered through 74 carriers. GM established a centralized eligibility and claims processing system that has resulted in significant cost savings.

- **IBM**--A company-financed FFS plan provides benefits to employees and dependents without premium charges to enrollees. Deductibles vary with salary for highly paid employees.

- **Marriott**--A single company-financed FFS plan has four options of varying generosity and employee cost.

- **Pacific Telesis**--A three-option FFS plan includes incentives for enrollees to receive treatment on a precertified basis in contract facilities. One option has flexible features that include additional cash pay. This plan differentiates among family member types in assessing enrollee premium charges.

- **Xerox**--This plan has two unusual features. Deductibles in the FFS plan are related to salary. A separate employee assistance program is designed to encourage early intervention and treatment for employees with substance abuse and mental health problems.

- **New York City**--Employees are offered a choice among 13 plans of varying types. Basic coverage is fully paid by the city for both employee and dependent coverage. Additional supplementary coverage (e.g., for drugs) may be purchased by employees.

- **San Bernardino County**--A single FFS plan has three options that vary in choice of provider and employee cost sharing. Employees can switch among the options at will. A flex plan allows additional cash pay for those who use less in health and dental benefits.

- **State of California**--Choice among FFS plans has recently been consolidated within one State-financed plan with a PPO option. A flex plan includes a low-cost FFS plan as an optional benefit.

- **State of Georgia**--A two-option FFS plan is part of a flex plan that includes a wide range of other benefits but does not allow the option of receiving added cash pay.

- **State of Maryland**--The State's choices cover an unusually wide range of options. For example, deductibles range from $150 to $2,750 for individual coverage. The health plan is part of a flex plan that includes a number of optional benefits, flexible spending accounts for health and dependent care expenses, and an option for additional cash pay.

Allied-Signal

Beginning in 1982, Allied-Signal took a number of steps to mitigate the rise in its health care costs. It increased enrollee cost sharing through deductibles and coinsurance, raised enrollee contributions, adopted utilization management programs, and adopted provisions to encourage outpatient services. In addition, the company offered more than 100 HMOs and later established PPOs in two locations. While these efforts met with early success, by 1987 costs began to increase rapidly. In response, Allied-Signal replaced this system with a plan that increased employee selection of health providers but shifted the risk of increased costs to an outside insurer. In 1988, Allied-Signal entered into a 3-year contract with CIGNA under which the insurance company has guaranteed that Allied-Signal's health care costs will not exceed a fixed rate. CIGNA is at risk for any costs that exceed this guaranteed amount; should it keep costs below this level, it will retain the resulting savings.

Allied-Signal's new program, *The Health Care Connection*, uses benefit incentives to encourage employees and their dependents to use CIGNA's network of selected physicians and dentists. These health care providers have signed agreements with CIGNA that give them the financial incentive to deliver services efficiently. The program has many of the design features of an HMO, with the added option of coverage provided by a non-network provider, but no other HMOs are offered in areas where CIGNA health plans are situated.

If enrollees use the network, CIGNA pays plan benefits directly to the provider. In most cases, the individual pays nothing; in other cases, only a small copayment is required. The enrollee can choose from among qualified medical service providers and does not have to fill out any claims forms.

If the network is not used, individuals have to pay the provider directly and the plan will reimburse the individual after a deductible and coinsurance amount. While there is no overall deductible or maximum out-of-pocket limit for benefits received from a network provider, there is an individual deductible of 1 percent of annual pay (3-percent family maximum) for services received from a non-network provider, after which the plan pays 80 percent of R&C. There is also an out-of-pocket limit of 4 percent of annual pay (12-percent family maximum) before expenses are reimbursed at 100 percent.

Allied-Signal reports that initial employee reaction to the program is favorable. Former FFS plan participants can realize an enhanced benefit--100 percent coverage in most cases--for in-network services. Former HMO enrollees, who were accustomed to comprehensive benefits but restricted access, are now eligible for benefits for services received out-of-network.

Bell Atlantic

Bell Atlantic has a core health insurance plan with an HMO option. Employees can elect additional coverage for dental care and vision care. The core plan is self insured and managed by a private carrier under contract.

The core health plan now has three options--catastrophic, low and standard. (A high option was ended due to risk selection problems.) All three options offer 80 percent coinsurance on most services, with 100 percent coinsurance available for certain cost containment items, such as surgery for which second-opinion approval was obtained. The deductibles vary as follows: catastrophic, $3,000; low, $300; standard, $150. Family deductibles are twice the individual amounts. Out-of-pocket limits are as follows: catastrophic, $4,000; low, $2,000; standard, $1,000. Family out-of-pocket limits are also twice the individual limits. Deductibles do not count against these limits. Thus, actual expenditures by an employee with Self Only coverage in the catastrophic option could reach $7,000 or more (the $3,000 deductible plus the $4,000 out-of-pocket limit plus any uncovered charges).

The health plan is part of a flex plan. The other benefits include life insurance, accidental death and dismemberment benefits, long-term disability benefits, a thrift savings plan, and flexible spending accounts for health care and dependent care. When Bell Atlantic's benefit allowances exceed the cost of an employee's elections, the employee can receive the balance in additional cash pay.

Bell Atlantic has automated the benefit enrollment process so that employees can make their benefit decisions by using either a touchtone phone or a personal computer. Using a phone, codes are entered that tell the computer which choices a particular employee has made. Using a computer, the employee enters choice selections on the left side of the screen. The right side of the screen immediately informs the employee of the impact a choice has on his/her net pay after taxes and deductions. The computer system provides personalized information drawn from a data bank that incorporates each employee's payroll data and information on age, sex, and family composition.

General Electric

General Electric's (GE) Comprehensive Medical Benefits plan covers the bulk of GE employees. There are options such as HMOs and PPOs available at certain localities, but all employees retain the option to stay in the basic benefit plan. The same benefits are available to union and to non-union members. GE also has a network of health care managers throughout the company, and, in concert with carriers, the managers are implementing a variety of cost containment measures based on the local health care marketplace.

GE's hospital review program consists of three parts:

- *Precertification of admissions* to establish the medical necessity of admission.
- *Concurrent review* to determine appropriate length of stay and level of care based on professionally recognized quality standards.
- *Discharge planning* to arrange in advance the most appropriate health care setting for a patient after discharge from a hospital, based upon the level of treatment required.

The amount of insurance protection depends on the type of expense incurred, with a lifetime maximum payment of $750,000. Covered medical expenses are of four types. The first category for expenses such as room and board and hospital services is paid for at 100 percent for 365 days. However, failure to meet the hospital review program for a nonemergency hospital admission results in the expenses being paid at 50 percent, rather than 100 percent. The second category of expenses is paid at 100 percent of the first $500 of expenses and 85 percent of any additional expenses. This includes surgical services, anesthetics, X-rays and diagnostic tests. Medical expenses in the third category are paid at 85 percent after a $100 deductible is met. This category includes physicians' services, including specialists, in a hospital, home, or elsewhere. The fourth category is medical expenses related to vision care. These benefits are paid up to a maximum dollar amount, ranging from $25 for an eye examination to $80 for trifocals.

Before January 1, 1989, no contributions were required for employee coverage. However, enrollees now pay a modest amount for their health insurance coverage on a pretax basis if their annual pay is $25,000 or more. The weekly contribution begins at $1 for someone earning between $25,000 and $37,499, and scales up in dollar increments reaching $5 a week for someone earning $100,000 or more. For dependent coverage, an enrollee is charged 2 percent of pay on annual earnings up to $10,000, resulting in a maximum annual contribution of $200 in 1989.

General Motors

General Motors (GM) offers its employees a choice between one of three health insurance options--a traditional FFS plan, a PPO, and an HMO. The FFS plan does not cover certain benefits such as home or office visits by a physician. The PPO, however, covers such expenses at 70 percent and offers additional benefits such as well-baby care, immunizations, and a lower copayment on prescription drugs. The HMO coverage also differs from the traditional FFS option. Such care generally is provided at little or no cost to the enrollee. HMO coverage also differs from the PPO, in that an HMO does not pay for charges incurred outside the HMO system, except for emergencies and referrals.

The benefit package is the same for salaried employees and hourly workers with certain exceptions. Hourly workers have first-dollar coverage under the FFS plan, but salaried employees are subject to an annual $200 individual deductible ($250 for a family) and are responsible for a 20-percent coinsurance for most expenses up to the maximum annual out-of-pocket limit of $700 ($750 for a family). Hourly workers also are provided vision and hearing aid coverage, whereas salaried employees must pay for half the cost of this additional coverage. This is the only enrollee premium charged. Dental coverage is available to all employees regardless of health care option selected, but salaried employees may trade in dental coverage for flex credits or cash.

The health benefit plan, known as the Informed Choice program, uses a centralized eligibility and claims processing system developed by Electronic Data Systems (EDS) Corporation. Before this centralization, employee health care claims had been administered primarily through 75 different Blue Cross/Blue Shield (BC/BS) carriers and commercial insurance companies throughout the country. In addition, GM had agreements with 125 HMOs.

GM revamped its health benefit plan in 1985 after it found that its health care costs had been escalating at 14 percent a year for 10 years, more than double the national average. GM had lacked the tools to collect and analyze information about how benefit dollars were spent or to predict trends. Moreover, there was no way to ensure that carriers paid claims uniformly throughout the country or that benefits were paid only to people who were covered under the program.

GM claims that its revamped Informed Choice program, developed with the support of the United Auto Workers (UAW), has sharply reduced GM's annual cost increases to 7 percent, saving approximately $794 million in health care costs over the first 3 years. Much of the initial savings was from tightened benefit eligibility. GM expects savings to total more than $1.5 billion by the end of the decade. The new system did not disturb the existing infrastructure; employees did not see any changes in their health benefit plan, and local carriers still decide what claims will be paid. However, GM now has national data and can report back to carriers whether or not they are meeting their cost containment goals.

IBM

IBM offers one FFS plan (the IBM Medical Plan), which is fully paid for by the company. Several insurance carriers administer the claims payments and provide other administrative services for coverages under contracts with IBM. IBM also offers a choice of membership in a federally qualified HMO as an alternative to the IBM Medical Plan, if one exists in the worksite area. If an employee enrolls in an HMO, the company will pay an amount equivalent to the cost of providing coverage under the IBM Medical Plan. Additional costs, if any, are paid by the enrollee through monthly payroll deductions. Regular part-time employees generally receive 75 percent of the benefits of regular full-time employees.

The IBM Medical Plan has five components: a Hospitalization Plan, a Surgical Plan, a Major Medical Plan, a Dental Plan, and a Personal Health Account (PHA). The Hospitalization Plan generally pays 100 percent of medically necessary inpatient care in a semiprivate room after satisfaction of a deductible. The Surgical Plan reimburses surgical expenses in full when they fall within the usual and prevailing level as determined by the carrier with whom IBM has contracted to pay claims. The Major Medical Plan pays 80 percent of other eligible expenses after satisfaction of an annual deductible. The Dental Plan provides assistance toward dental care, subject to individual lifetime limits, based on a schedule of allowances that varies by geographical area. The PHA, which is funded by IBM, provides assistance for certain preventive medical care and vision and hearing care costs not covered under the other medical plans.

The IBM Hospitalization Plan generally pays 100 percent of all covered charges, except for a deductible of 40 percent of the first day's room and board charge. This deductible does not apply to other charges such as lab, X-rays, medications, or therapy. The purpose of this provision is to increase the employee's role in controlling hospitalization costs and encourage outpatient care where appropriate. The overall plan deductible under the Major Medical Plan is 0.3 percent of year-end salary, with a $150 minimum. Thus, the deductible remains at $150 for employees earning up to $50,000. The Major Medical Plan has an overall $250,000 lifetime family maximum ($25,000 individual lifetime benefit for outpatient psychiatric treatment). There is no deductible or lifetime maximum under the Surgical Plan. However, if a second surgical opinion is not obtained for one of the listed procedures, reimbursement of the surgical fee is at 80 percent of the usual and prevailing rate instead of 100 percent.

In 1985 IBM included incentives and alternatives to hospitalization. Home health care, extended care facilities, birthing centers, and hospice care for the terminally ill are reimbursed, subject to limitations, at 100 percent.

The IBM PHA provides reimbursement of 80 percent of eligible charges up to an annual maximum benefit of $200 per employee. There is no annual deductible. The PHA can be used for medical tests and examinations that are not for treatment of an injury or illness, such as pap smears, blood sugar and cholesterol tests, immunizations, and hearing and eye tests.

Marriott

Marriott offers its employees a choice between company-sponsored HMOs and an FFS plan insured and managed by Marriott. The FFS plan, called Multi-Med, has four options, each of which has different enrollee cost-sharing arrangements. Employees elect an option during an annual open season. Since Marriott has a tax-qualified flexible benefits plan, premiums can be paid from before-tax salary. Premiums are set for the following categories: employee, employee and one dependent, and employee and family.

Four features of Multi-Med vary among the four options: deductibles, coinsurance rates, out-of-pocket limits, and coverage of routine physical exams. The deductible varies from $150 to $500 ($350 to $1,150 for a family). Coinsurance ranges from 90/10 to 70/30. The per-person limit on annual out-of-pocket expenses ranges from $900 to $2,000. However, coverage of routine physicals varies in the reverse direction, with the most generous plan paying $60 a year and the least generous paying $100. The reason for this feature is to avoid discouraging use of preventive health care services by those who elect the less generous options.

To minimize adverse selection, when an employee elects a higher option under Multi-Med, treatment of pre-existing conditions that were treated within the 6 months immediately preceding the election are reimbursed under the terms of the old option for the first 12 months under the new option.

Enrollment in the Marriott health plan automatically covers the enrollee for accidental death and dismemberment benefits. A dental plan is offered separately. Dental premiums can also be paid from before-tax salary.

Aside from the options to convert premiums into before-tax deductions, Marriott's only flexible benefit feature is leave selling, called BeneTrade. The firm permits employees to trade in up to 20 percent of vacation and sick leave in exchange for reduced insurance premium charges.

Pacific Telesis

Pacific Telesis offers employees a choice among three FFS plans and several HMOs. The company has contracted with area hospitals to provide care to covered employees at negotiated rates. Separate plans provide coverage for dental care, vision care, mail order prescription drugs, and substance abuse treatment. A separate FFS health plan is maintained for retirees.

The three FFS plans offered are called CMP, BenMed, and FlexTel. CMP is a traditional plan; BenMed uses fee schedules to establish benefit levels; FlexTel offers two options, the lower of which yields a supplement to an employee's cash pay.

CMP has a deductible of $150 ($300 per family). Out-of-pocket expenses are limited to $1,000 per year ($2,000 per family). Precertified inpatient care in a contract hospital has a 95-percent coinsurance rate. Most other services have 85-percent coinsurance.

BenMed also has a $150 deductible and a $1,000 out-of-pocket limit. The family deductible is $450. Precertified inpatient care in a contract facility and precertified surgical care are paid in full by the plan. Other services are paid according to a schedule of fees established each year.

FlexTel has two options. Option A has a $150 deductible ($300 per family) and an out-of-pocket limit of $1,000 ($2,000 per family). Option B has a $300 deductible ($600 per family) and an out-of-pocket limit of $2,000 ($3,500 per family). Option A pays 95 percent of precertified inpatient care in a contract facility and 85 percent for most other services. Option B's coinsurance rates are 90 percent and 80 percent, respectively.

Employees who elect FlexTel Option B are credited with $25 for each month of enrollment. During open seasons, such credits can be designated for any of the following: payment of medical expenses not covered by FlexTel, payment of dependent care expenses, or additional cash pay. Only the last form of receipt constitutes taxable income.

There is no premium charge to enrollees for their own coverage or for their class I dependents (spouses, dependent children under age 24). Premiums are charged for other dependents, who can include any relatives who meet tests of dependency and income. "Sponsored children" ages 19 to 24 who are unmarried but not dependent on their parents may also be covered subject to premium charges.

Xerox

Xerox employees can choose from one FFS plan (Xerox Medical Plan) and up to seven HMOs. Rather than having a uniform dollar deductible, the Xerox Medical Plan has an annual deductible of 1 percent of salary. Once the family has total expenses in excess of the deductible, plan benefits become payable for all family members. The Xerox Medical Plan covers hospital room and board, inpatient physician care, other hospital services, inpatient and outpatient surgery, and other medical services at 80 percent of R&C after the deductible has been met. Preventive medical care is not covered. There is a family maximum out-of-pocket of 4 percent of salary. Once that amount is reached, the plan pays 100 percent of additional expenses (except for outpatient psychiatric, for which the plan pays 50 percent). Dental care is offered through a separate plan.

Xerox pays the full premium cost for single persons. Enrollees pay monthly premiums of $25 for one dependent and $46 for family coverage in 1989. Xerox contributes $400 to a Flexible Benefit Account (FBA) for both active employees and retirees regardless of health plan choice. (Employees can also redirect $2,000 of pay into this account for health care expenses and $5,000 for dependent care assistance.) The account can be used to reimburse the employee on a tax-free basis for out-of-pocket expenses, but not premium contributions. Enrollee premiums are deducted from before-tax pay; therefore, they cannot be reimbursed from the FBA.

In 1979, the Xerox Employee Assistance Program, or XEAP, was established to provide help for alcohol or drug abuse, as well as personal, emotional and family problems. Xerox has contracted with Family Service America, a nationwide network of more than 7,000 professionals, to provide individual counseling and referral to deal with these problems. The XEAP program is available to employees in all 50 States as well as to retirees and dependents. The goal of XEAP is to provide an effective way of dealing with these problems before they reach the crisis stage.

XEAP pays for 100 percent of the charges for two diagnostic visits with a network provider and 80 percent of the contracted rate for the next four visits. The XEAP reimbursement is not subject to the Xerox Medical Plan deductible, and the 20-percent coinsurance does not count toward the out-of-pocket maximum. Enrollees can be reimbursed for their cost sharing amounts from their Flexible Benefit Account. Xerox has retained an independent company, American PsychManagement, to work with mental health care providers in providing a treatment plan. If the enrollee does not use the XEAP or fails to submit a certified treatment plan, the company pays only 50 percent for either 10 outpatient visits or 10 inpatient days. Any subsequent treatment beyond the initial six visits is covered under either the Xerox Medical Plan or the HMO selected.

New York City

New York City offers its active employees and retirees a broad choice among 13 health benefit plans. Through collective bargaining agreements, the city and municipal unions have cooperated in the design of the health benefit package, ranging from FFS plans to HMOs and PPOs. One plan is specifically tailored for Medicare-eligible retirees. Some of the plans are not available to everyone.

Eight of the 13 plans are designed to pay in full the charges for most covered medical services from participating medical groups and health care providers. While coverage is comprehensive, enrollees may purchase optional rider benefits for prescription drugs, as well as certain other services such as private duty nursing. For the five HMO plans requiring enrollee contributions through payroll deductions, the optional rider consists only of a prescription drug plan. The city's contribution to these HMO plans equals its payment to the Health Insurance Plan/Health Maintenance Organization (HIP/HMO), the largest HMO outside of California. The enrollee pays any difference.

Under collective bargaining agreements, the city makes per capita contributions to union welfare funds. The trustees determine the supplemental benefits to be offered its membership such as vision care and extra catastrophic protection. If the employee's union welfare fund offers some or all of the benefits contained in a rider, those specific benefits are paid by the welfare fund. In such cases, payroll (or pension) deductions are reduced accordingly.

San Bernardino County, California

San Bernardino County employees are offered a choice among two HMOs and a triple option plan called Flex-Med. The HMOs are Partners Health Plan, which is an IPA, and Kaiser Permanente, a clinic-based HMO. Flex-Med's three options are called Choice Care, Select Care, and Preferred Care. Dental care is offered separately through two plans, an FFS plan with a PPO option, and a prepaid dental plan which serves patients in a clinic setting.

The Kaiser HMO has no deductible and charges only small copayments for selected services. There is an annual out-of-pocket limit of $1,000 ($2,830 per family). The Partners HMO has a $50 deductible for prescription drugs and charges coinsurance for certain services (e.g., 20 percent for ambulatory surgical center care, 50 percent for allergy testing, speech therapy, and physical therapy). The out-of-pocket limit is $850 ($1,700 per family).

The Flex-Med plan allows participants to switch among the three options when and as often as they wish at point of service. The options are an FFS plan (Choice Care), a PPO (Select Care), and publicly provided care (Preferred Care). The options are structured so that enrollee cost sharing grows with the degree of flexibility an option offers in selection of providers. Choice Care, with no restrictions on provider selection, has a $300 deductible ($600 per family) and 80/20 coinsurance on most services. Select Care, which restricts provider selection to an approved list, has a $150 deductible ($300 per family) and 80/20 coinsurance. Preferred Care also restricts provider choice to an approved list, but it requires less cost sharing if services are received at the County Medical Center or County Health Centers. Such care at county facilities incurs no deductible and no cost sharing except for convalescent care and substance abuse treatment. Flex-Med has an annual out-of-pocket limit of $4,000 for all options.

Enrollees share in the premium costs. Enrollee premiums for Flex-Med are about 15 percent less than for the HMOs. Premiums are established for three enrollee categories: employee only, employee and one dependent, and employee and two or more dependents.

San Bernardino County offers employees a flexible benefit arrangement that may be used for employer payment of employee health premiums. Benefit credits are determined by a formula that varies by employee category. For example, the credit amount for management personnel is $275 per month plus 5 percent of salary. These credits are applied in the following order: (1) payment of employee retirement plan contributions; (2) payment of employee health and dental insurance premiums; and (3) additional cash salary. A flex plan participant must enroll in a county health plan unless enrolled as a dependent of a spouse who is also a county employee.

State of California

The State of California offers its employees a choice among a State-run PPO (PERS-CARE) and 23 HMOs. FFS plans offered by private carriers were ended as of January 1, 1989, in a move by the State to contain cost increases in FFS plans. Law enforcement and firefighter associations continue to operate member-only PPOs, however. PERS-CARE and the other PPOs cover care outside their approved networks, subject to higher enrollee cost sharing. In 1987, 40 percent of PPO services occurred outside the preferred networks.

PERS-CARE was begun in 1989 and replaces employee plans of private carriers. PERS-CARE is both insured and managed by the State. Contractors provide claims processing, mail order prescription drugs, and case management. The system is using Blue Shield's provider network. There is a $200 deductible ($400 per family), which is waived for inpatient hospitalization and certain preventive care services. Enrollees pay 10 percent of the cost of most services, up to an annual out-of-pocket limit of $1,000 ($2,000 per family). Use of non-PPO providers results in 40-percent coinsurance for most services, and the out-of-pocket limit is $3,000 ($6,000 per family).

A wide variety of HMOs are offered, including hospital-based plans, IPAs, clinic networks, and clinic/IPA combinations. Los Angeles and Alameda Counties each have 10 HMOs in operation. Nearly 70 percent of enrollees have access to at least six HMOs, although one-sixth of enrollees live in areas not covered by HMOs. Over half of the enrollees are currently in HMOs. The State is considering a reduction in the number of HMO options in the future.

Total premiums for HMO plans are 25 to 30 percent less than for PERS-CARE. The formula for the State's contribution leaves most HMO premiums fully paid by the State, but enrollees pay part of the PERS-CARE premium. Premiums are set for three enrollee categories: employee only, employee and one dependent, and employee and two or more dependents.

As a cost reduction measure, California law allows disputes over medical care to be settled by binding arbitration rather than through court trials. Most of the carriers for the State employee plans have elected to use binding arbitration.

Retirees eligible for Medicare are enrolled in a Medicare supplement plan. The amount the State pays toward premiums is the same as for active employees. However, retirees hired after December 31, 1984 must have at least 10 years of service to qualify for the full State contribution. For those first hired after December 31, 1988, the service required for the full contribution is 20 years. Recent legislation has authorized the prefunding of retiree health benefits; implementation is under study.

California has a flex plan for its managerial, supervisory and exempt employees. This voluntary plan allows the use of flexible spending accounts for medical and dependent care expenses. It has a cash option for those who do not elect health or dental insurance or who elect a low-cost health plan (described below). As much as $84 a month can be received in cash through this means. An equivalent amount can be contributed to the State's deferred compensation (section 457) plan to avoid an overall increase in taxable salary.

The low-cost health plan available as a flex plan option is a PPO with a $500 deductible ($1,000 per family). Coinsurance of 10 percent is required for most services (25 percent from non-PPO providers). The annual limit on out-of-pocket expenses is $25,000.

State of Georgia

The State of Georgia offers its employees a choice of health coverage under a high option plan, a standard option plan, or an HMO. The high-option plan pays 100 percent of hospital care compared to 90 percent for the standard option. After a deductible of $150 ($600 per family), the high option pays 90 percent of physician services compared to 80 percent under the standard option. The out-of-pocket limits are $400 ($1,000 per family) for the high option and $1,200 ($3,000 per family) for the standard option. The HMO option is not available to all employees since some counties have no established HMOs.

The State pays about 75 percent of the premium cost for all options. Premiums are set for two enrollee categories: single and family. Employees may elect to pay the premiums from before-tax pay in order to realize tax savings.

Georgia's employee health plan is part of a flexible benefits program. The other benefits available in the flex arrangement are employee and dependent life insurance, accidental death and dismemberment (AD&D) benefits, short-term disability insurance, long-term disability insurance, dental insurance, and flexible spending accounts for medical expenses and child care expenses.

The flex plan allows the employee to select a level of coverage for each of the benefits offered. Three levels of life insurance and AD&D are offered, and the health insurance choices are as stated above. The other benefits are elected on an all-or-nothing basis. Salary reductions for use in the spending accounts are limited to $3,000 for medical and $5,000 for child care. There is no option to receive additional cash pay in lieu of benefits.

State of Maryland

The State of Maryland offers its employees and retirees an enrollment choice among two FFS plans, a preferred provider network, or any of 11 HMOs. Since 1985 Maryland has self insured its three non-HMO plans and has a contract with BC/BS to pay claims and provide member services.

Employee premiums are paid on a before-tax basis and vary considerably by plan selected and coverage category (i.e., single, married, family, or single parent). In addition, premiums for retirees vary depending on Medicare coverage and family composition. For additional premiums, employees may purchase catastrophic health care protection. They also have the option of purchasing a prepaid dental plan, a long-term care plan, a vision care plan, and a family prescription drug plan. (The State subsidizes the "employee only" level of coverage of the prescription drug plan at 100 percent).

Employees who want to minimize their premium costs may do so at the risk of incurring relatively high out-of-pocket costs. The BC/BS Traditional Option (which was formerly known as the High Option plan) charges enrollee premiums that are about four times higher than the Preferred Provider Network (PPN) or the BC/BS Comprehensive Option. In turn, it pays 100 percent of R&C for hospital services after a $150 individual/$450 family deductible is met. This compares to 20 percent enrollee coinsurance after a $750 individual/$1,875 family deductible is met under the BC/BS Comprehensive Option. The traditional plan's annual out-of-pocket limit is very low ($150 individual/$450 family) compared to the comprehensive option ($2,750 individual/$6,785 family). There are no deductibles or out-of-pocket limits for the HMOs since services and benefits are covered in full, other than an occasional copayment.

The State of Maryland also offers its employees a cafeteria plan, which lowers the amount employees spend on their health benefits by "giving back" some of their pay so that the State pays for the benefits on a before-tax basis. Since January 1, 1988, employees automatically received this tax break if they chose any kind of health coverage, the dental plan, or dependent coverage under the vision or prescription plan. Beginning January 1, 1989, this menu was expanded to catastrophic health insurance, personal accident insurance, and group-term life insurance. The taxes saved become extra take-home pay.

Employees may establish a health care reimbursement account as a cost-effective way to pay for expenses that are not covered by insurance. Employees can contribute up to $3,000 of pretax pay into their account each year. The health care reimbursement account can be used to pay such expenses as medical and dental plan deductibles and copayments, vision care expenses, and orthodontia. In addition, employees may contribute up to $5,000 each year to a dependent care reimbursement account to pay for dependent care that takes place inside or outside the home.

E. Comparison of Total Compensation for Federal vs. Private Sector Employees

Employer-based health insurance is but one of several forms of employee compensation offered by most large U.S. employers. The relative value of health benefits in the total compensation package varies among employers, and, of course, the size of the total package varies as well.

In considering FEHBP changes, Congress will be concerned with the cost of any change. This section compares the current cost of FEHBP to the cost of private-sector employee health benefits. It also compares other types of compensation in order to put the health comparison in a larger perspective.

These benefit comparisons were developed for CRS by Hay/Huggins and are shown in tables 5.2, 5.3, and 5.4. The figures for retirement benefits represent the actuarial cost for a hypothetical employee averaged over the employee's entire career. For other benefits, the figures are the average benefit cost per employee for 1989. The benefit values presented here reflect the benefits *available* to typical employees at different salary levels, not the actual pattern of benefit utilization.

1. *Health Benefits*

For a Federal employee, the average 1989 value of the Government contribution to health insurance coverage is $2,861.[44] A private-sector employee earning $30,000, which is the average Federal salary, could receive an employer health benefit worth $3,960, a benefit that exceeds the average Government contribution to FEHBP by 38 percent. (This 1989 gap in health benefits values is about twice that found by Hay/Huggins in a 1984 study.)[45]

The private-sector advantage is greater for workers at higher salary levels.[46] At a salary of $60,000, the private-sector benefit's value exceeds FEHBP's by 44 percent.

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[44] This average results from dividing the total Government contribution for health insurance premiums by the number of enrolled employees. It is not the same as the Government contribution to premiums for Self Only coverage for a Federal employee, because this average 1989 value of the Government contribution takes the Government cost for all employees into account, including those with Family coverage.

[45] U.S. Congress. House. Committee on Post Office and Civil Service. *Study of Total Compensation in the Federal, State and Private Sectors.* Committee Print 98-16, 98th Cong., 2nd Sess. Washington, U.S. Govt. Print. Off., Dec. 4, 1984.

[46] The increasing value of private-sector health benefits as salary increases reflects plan designs that may be modified once the nondiscrimination rules of section 89 of the Internal Revenue Code are fully in effect.

The private-sector advantage reflects the fact that the typical practice is to charge employees nothing in premiums for their own coverage and to charge them 25 percent of the cost of dependent coverage, whereas Federal employees in 1989 paid, on average, about 29 percent of FEHBP premiums. Another reason for this difference is that deductibles tend to be higher in the Federal FFS plans than in private-sector plans.

2. *Retirement Benefits*

Federal retirement benefits exceed private sector benefits. For the employee earning $30,000, the Federal Employees Retirement System (FERS) pension is valued at $3,741, and the Thrift Savings Plan is valued at $1,350, for a total retirement package of $5,091. In contrast, the private sector retirement package's value is only $3,804, or 26 percent less. A similar difference is found at other salary levels. The Federal advantage is smaller than it was in the 1984 Hay/Huggins study because the new FERS is less costly to the Federal Government than the Civil Service Retirement System (CSRS) it will eventually replace.[47] (The CSRS benefit of $7,690 for the $30,000 employee exceeds the private-sector pension benefit by $4,598, but about half of this difference is offset by the lack of social security coverage for CSRS employees.)

3. *Other Benefits*

The other major fringe benefits reach similar levels for the $30,000 worker when the two sectors are compared. Small advantages for the Federal employee in vacation time are offset by private sector advantages in disability and death benefits and executive perquisites.[48] All of these benefits taken together cost $4,872 for the $30,000 Federal employee, compared to $5,149 for the private-sector counterpart. The private-sector advantage is greater at higher salary levels, reaching 24 percent at $80,000.

4. *Total Compensation*

Taking into account a cost of $2,485 for statutory benefits (social security, Medicare, unemployment compensation) that apply in both sectors at the $30,000 salary level, the total available benefit package costs the employer 51.0 percent of pay for the typical Federal employee under FERS, 53.4 percent of pay for the typical Federal employee under CSRS, and 51.3 percent of pay for a comparable private-sector worker. For a $60,000 employee, the corresponding figures are lower, but the decline is relatively smaller for the private-sector employee: FERS, 43.6 percent; CSRS, 47.8 percent; private sector, 46.8 percent.

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[47] FERS was enacted in 1986 as a supplementary pension system for Federal employees covered by social security. CSRS, designed for employees not covered by social security, is a closed system that will eventually be phased out through the deaths of its participants and their survivors.

[48] Executive perquisites include such benefits as deferred compensation plans, company-provided transportation, financial planning services, and club memberships.

When a comparison of total employee compensation includes pay as well as benefits, private-sector employees are shown to fare better than Federal employees. Studies of pay comparability between Federal and private employers have shown consistently that Federal pay lags private-sector pay. The most recent review by the Advisory Committee on Federal Pay indicates that the gap averaged 26.3 percent in 1988, an increase from 18.3 percent in 1984.[49]

5. *Conclusion*

The Government contribution to FEHBP for a Federal employee lags far behind the value of employer contributions to health coverage in the private sector, but the Federal advantage in retirement benefits offsets this difference in health benefits. However, when pay is considered in the comparison, the combined total of wages and benefits is greater for the private worker.

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[49] This committee's findings have been disputed, but there is no other comparable study available.

TABLE 5.2. Annual Value of Federal Contribution to Benefits for Employees Covered by FERS, 1989

	Annual Salary						
	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000
Health care	$2,861	$2,861	$2,861	$2,861	$2,861	$2,861	$2,861
FERS Pension	2,494	3,741	4,988	6,235	7,482	8,729	9,976
Thrift plan[a]	900	1,350	1,800	2,250	2,700	3,150	3,600
Death benefits[b]	191	261	332	403	474	545	615
Disability benefits	678	1,040	1,407	1,775	2,141	2,508	2,875
Leave	2,381	3,571	4,762	5,952	7,142	8,333	9,523
Statutory[c]	1,770	2,485	3,200	3,379	3,379	3,379	3,379
Executive perquisites	0	0	0	0	0	0	0
Total[c]	$11,274	$15,310	$19,350	$22,854	$26,179	$29,504	$32,830
Federal benefits (including FERS pension) less private sector benefits[d]	-197	-88	-152	-855	-1,887	-2,643	-3,445

[a] These estimates reflect the fact that FERS-covered employees who participate in the thrift plan received an average Federal contribution worth 4.5 percent of salary.

[b] Includes employer subsidy of life insurance premiums.

[c] Social security, Medicare and unemployment compensation.

[d] Detail may not add to total due to rounding.

Source: Analysis prepared for CRS by Hay/Huggins Company, Inc.

TABLE 5.3. Annual Value of Federal Contribution to Benefits for Employees Covered by CSRS, 1989

	Annual Salary						
	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000
Health care	$2,861	$2,861	$2,861	$2,861	$2,861	$2,861	$2,861
CSRS Pension	5,127	7,690	10,254	12,817	15,380	17,944	20,507
Thrift plan	0	0	0	0	0	0	0
Death benefits[a]	118	177	236	295	354	413	472
Disability benefits	740	1,110	1,480	1,851	2,221	2,591	2,961
Leave	2,381	3,571	4,762	5,952	7,142	8,333	9,523
Statutory[b]	530	625	720	744	744	744	682
Executive perquisites	0	0	0	0	0	0	0
Total[c]	$11,757	$16,035	$20,313	$24,519	$28,702	$32,885	$37,006
Federal benefits (including CSRS pension) less private sector benefits[c]	286	637	810	810	636	738	732

[a] Includes employer subsidy of life insurance premiums.

[b] Social security, Medicare and unemployment compensation.

[c] Detail may not add to total due to rounding

Source: Analysis prepared for CRS by Hay/Huggins Company, Inc.

TABLE 5.4. Annual Value of Employer Contribution to Private Sector Benefits,[a] 1989

	Annual Salary						
	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000
Health care	$3,956	$3,960	$4,018	$4,088	$4,130	$4,172	$4,220
Pensions	1,961	3,092	4,329	5,656	7,021	8,343	9,748
Thrift plan	477	712	932	1,164	1,395	1,626	1,851
Death benefits[b]	303	417	543	685	807	956	1,078
Disability benefits	754	1,154	1,566	1,981	2,402	2,815	3,226
Leave	2.223	3,353	4,483	5,642	6,857	8,027	9,282
Statutory[c]	1,770	2,485	3,200	3,379	3,379	3,379	3,379
Executive perquisites	27	225	430	1,114	2,075	2,830	3,490
Total[d]	**$11,471**	**$15,398**	**$19,502**	**$23,709**	**$28,067**	**$32,147**	**$36,274**

[a] Private sector benefits were valued using data for large and medium employers as reported in the *1988 Hay/Huggins Benefits Report*.

[b] Includes employer subsidy of life insurance premiums.

[c] Social security, Medicare, and unemployment compensation.

[d] Detail may not add to total due to rounding.

Source: Analysis prepared for CRS by Hay/Huggins Company, Inc.

CHAPTER 6. THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: THE ISSUE OF CHOICE

Choice is a central feature of the structure of FEHBP. This chapter examines the available choices, the effects of choice, and the ways FEHBP could be modified to address problems with the current choice design.

The following are the primary conclusions about the effects of choice in FEHBP as discussed in this chapter:

- Choice does not significantly affect the total cost of FEHBP. If FEHBP ended its current choice design and offered instead a single plan with benefits that were typical of its current plans, the total cost of the program would be close to what it is today.

- Choice has lead to adverse selection, which, in combination with the rate-setting method under FEHBP, has had two results:

    -- Differences among the FEHBP plans in the enrollee premium are often much greater than the actuarial value[60] of the benefit differences, and

    -- Some individual plans have experienced spiraling costs.

- Because of the range of choices under FEHBP, potential enrollees may choose a plan whose benefits do not adequately cover their medical care expenses for one of two reasons:

    -- They find a plan with a benefit structure they anticipate they will need, but they do not choose that plan because they find it too expensive.

    -- They choose a plan based on cost without realizing that the plan does not sufficiently cover important services.

A number of changes that would address these effects of choice in FEHBP are discussed in this chapter, including:

- Specify a standard benefit design for all FEHBP plans for the major expenses of hospital admissions and surgical procedures. This would permit the enrollee to focus on fewer benefit differences and reduce the enrollee's risk of incurring high out-of-pocket expenses.

- Reduce the number of options available to each enrollee. This would simplify choice and should improve enrollee understanding of the remaining plan design differences among the FEHBP plans.

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[60] The actuarial value is the cost that a given plan's benefits would have if all FEHBP enrollees were in that plan.

- Set enrollee premiums based only on differences in the actuarial value of benefits. As a result, an enrollee would not have to pay for the cost of enrollees who have adversely selected the same plan.

- Permit controlled competition among different health care delivery and administration approaches for the same benefit design. The Government would use competition to reduce program costs.

- Change to a self-insurance approach with carriers acting as third-party administrators (TPAs). This would facilitate the four changes mentioned above and would simplify the enrollee's decision process.

- Allocate more resources to communications with potential enrollees, and better control the communications. This step is necessary in any program design to provide information needed for the choice decision.

This chapter presents general approaches to choice in employer-based health plans, discusses choice and its effects on FEHBP, and concludes with a discussion of possible changes that could improve the design, cost, and comprehension of choice in FEHBP.

A. What Is Choice?

This section discusses the general features of choice plans. Three aspects of choice are found in employer-based health benefits plans:

- Choice of the number of family members to be covered. For instance, many programs permit the enrollee to choose whether or not to cover the family;

- Choice among different benefit designs, or among supplements to a single plan that covers the major expenses; and

- Choice among different methods of health care delivery, such as fee-for-service (FFS) and health maintenance organization (HMO) plans.

If an employer requires the enrollee to pay part of the premium for health care, the cost usually varies depending on the number of family members covered by the plan. The least expensive coverage is for the enrollee alone. Most plans that require the enrollee to pay part of the premium offer one family rate, regardless of the number of dependents. The employer thus averages the different cost for different family sizes in one overall rate. Many private sector plans do offer a choice (and a corresponding premium difference) among several different family structures including spouse only, children only, spouse and one child, and spouse and all children.

Plans in the private sector that offer a choice of plans typically include coverage of hospitalization and surgical expenses that is standard for all options. The enrollee's choice is limited to improvements in the standard coverage of these major expenses and to additional coverage for other health care expenses. For instance, the enrollee could choose lower enrollee cost-sharing amounts than in the standard benefit package, or could choose supplemental plans for dental, vision, or prescription drug coverage.

The evolution of the health care delivery system has created choices among different methods of health care delivery. FFS plans offer enrollees choice among all qualified providers of services. This approach uses deductibles and coinsurance payments to encourage the rational and cost-effective use of care: deductibles to discourage enrollees from obtaining unnecessary services, and coinsurance to provide enrollees with an incentive to select cost-efficient providers of services.

HMOs attempt to reduce chronic care costs by offering preventive care and by controlling access to providers. This managed care approach helps to ensure appropriateness of care and limit expenses.

Preferred provider organizations (PPOs) use a combination of the FFS and HMO approaches. While encouraged to use the preferred providers, individuals may select other providers if they are willing to pay a greater part of the cost of treatment.

B. Choice in the Private Sector

1. Types of Plans

Since the HMO legislation of 1973,[51] employers have been required to offer federally qualified HMOs as a choice if an HMO wishes to be offered. Before 1980, choice in the private sector was largely limited to a choice between a FFS plan and one or two HMOs. The *1988 Hay/Huggins Benefit Report (HHBR)*[52] shows that 68 percent of medium to large firms had at least one HMO option. Also, according to the *HHBR*, 15 percent of employers offered a choice of FFS plans, usually as part of a flexible benefits plan. The private sector choice of plans discussed in this section are those that offer at least two FFS options in addition to HMO options.

The typical choice plan consists of two or three FFS options; there are probably no private sector choice plans that offer more than five options. This is a significant difference from the FEHBP approach of offering 20 or more FFS choices to every enrollee. The private sector choice plan is typically offered as part of a flexible benefits plan, which consists of a predetermined employer-paid credit to be used by employees in selecting among available benefits options. In many plans, employees may purchase additional benefits with pre- or post-tax dollars.

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[51] The Health Maintenance Organization Act of 1973, P.L. 93-222, Dec. 29, 1973.

[52] A survey of the benefits plans of 681 medium and large employers conducted annually by the Hay/Huggins Company, Inc.

Typically, employees must select a core health benefits plan, unless they can prove coverage under another plan (e.g., benefits are provided through the plan of the spouse's employer). Some plans provide options with higher levels of cost sharing. In addition to the core health benefits plan (or plans), the employee may elect to purchase additional life insurance, disability insurance, dental, vision care, or dependent care.

The choice plan options typically provide a core of benefits that are in all options. For instance, every option might have hospital care paid in full and all physician costs covered at 80 percent after a $200 deductible. The choice is limited to (a) improvements in the cost sharing, or (b) benefits for specific types of care such as dental care.

2. *Insurance Arrangements in Choice Plans*

Private sector choice plans do not offer a choice among insurers, other than the HMO and PPO options. The private FFS options are either self insured or they are underwritten by the same insurer. There is little advantage in having multiple insurers if the benefit package is standardized. If only one insurer offers all the options, it does not matter if adverse selection occurs against a particular option because the single insurer is underwriting all the risks in all options and so has no incentive to attract only the low risks to a particular plan.

The employer is not affected by adverse selection because of the way in which the employee rates are set. As described in the next section, the employer specifies an enrollee rate for the core benefits. Employees are then charged different premiums for the supplements, or other complete options, based on a schedule selected by the employer. This schedule could be based on the actuarial difference among benefit designs, or it could be modified to achieve other goals. In any event, the employer will set the enrollee rates so that, in total, they will generate a certain level of income. Since the employer is responsible for the balance of the premium cost, movement of enrollees among options do not affect the employer cost. This effect is demonstrated below.

3. *Impact of Rate-Setting Method on a Choice Plan*

The choice plan option selected by most enrollees is largely determined by the method by which the rates for the enrollees are set. The practice in private sector choice plans is to charge the enrollees a premium which reflects only the difference in the actuarial value of the benefits; the employer pays any premium cost due to the claims experience of the group of enrollees choosing that particular plan compared to the experience of all enrollees under the program. Enrollees then make a decision among plans based on rates that reflect any difference in the relative value of the benefits. In this approach, the enrollee does not pay for the risk level of other enrollees who choose the same option.

The typical private employer plan pays all of the premium for the enrollee's own coverage and most of the premium for the dependent's coverage. In a choice situation, the lowest price plan might be offered for no charge. If an employee were to choose a more expensive option, the employee would pay the cost difference.

In contrast, under FEHBP, the enrollee is charged not just for differences in benefit values but also for differences in risk. Thus, the differences in premium cost among plans can be much greater than the differences in the benefits, distorting choices for some enrollees and contributing to adverse selection.

The following discussion describes the impact of these two rate-setting approaches on a choice program. The example shows the premium impact in successive years of the program: in the base year, when the premium amounts represent the actuarial value of the benefits; in the first year of the choice program, following the first open season; and in the second year of the program, following the second open season.

The actuarial cost of an option is the cost if all enrollees participate in that option. For instance, if the only difference between two options were that one provided 75 percent coinsurance and the other 85 percent coinsurance, the cost of the second option would be 113.3 percent of the first.[53] If the cost of the first option were $1,000 a year, the enrollee could purchase the second by paying an additional $133. However, if there were adverse selection, the actual difference in cost between the enrollees in the two plans would be much greater than $133 because the higher-risk people would tend to choose the plan with higher coinsurance.

The following example (see table 6.1) will demonstrate the effect on premium of a selection between two options. A group of 2,000 enrollees is allowed to choose between two options. The options both have $200 deductibles, but one has 85 percent coinsurance (plan B) and the other has 75 percent coinsurance (plan A). In the illustration, the cost of a choice between two plans is compared with the cost of a single plan that has 80 percent coinsurance.[54]

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[53] The ratio of 85 percent to 75 percent is 113.3 percent. The actuarial difference would in fact be somewhat greater because the higher coinsurance could encourage higher utilization than in the illustration.

TABLE 6.1. An Example of Choice Between Plans Compared to Single Plan

	Choice design		Single plan design
	Plan A	Plan B	Single plan
Deductible	$200	$200	$200
Coinsurance	75%	85%	80%

As shown in table 6.2, the average medical expense for the entire group is $2,100, with half of the enrollees having expenses that average $2,600 a year (high risk group II) and the other half having expenses that average $1,600 a year (low risk group I). If all of the enrollees are in a single plan, the average benefit will be $1,520.[55] If these were the only plan costs, the total average premium would also be $1,520.

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[54] Because of predictable utilization differences, the 80 percent plan would not have an actuarial value that is the same as the average of the 75 percent and 85 percent. Also, the total cost of the plan would be the cost of the benefits plus administrative expenses and reserves. To focus on the direct interaction of the two options, these factors are not considered in the illustration.

[55] Eighty percent of the total expenses of $1,900 that remain after the $200 deductible.

TABLE 6.2. Expenses And Benefits by Risk Group, Single Plan

	Average expenses	Number	Total expenses
Low risk group I	$1,600	1,000	$1,600,000
High risk group II	2,600	1,000	2,600,000
Total	$2,100	2,000	$4,200,000

All in Single Plan

	Average benefits	Number	Total benefits
Low risk group I	$1,120	1,000	$1,120,000
High risk group II	1,920	1,000	1,920,000
Total	$1,520	2,000	$3,040,000

Table 6.3 shows the average cost of each option in the first year of the program, after the first open season. The employer is assumed to have set the difference in premiums for plans A and B equal to the $190 actuarial difference[56] in benefit value. It is assumed that there is a moderate preference for the better coverage (plan B) among those in high risk group II and a moderate preference for the less expensive plan (plan A) among those in low risk group I.

The actual cost difference of $350 between plan B ($1,700) and plan A ($1,350) is greater than the $190 actuarial difference because of the adverse selection. In other words, the actual cost of plan B is $85 higher than its actuarial cost because of the greater number of high-risk individuals choosing that plan; the actual cost of plan A is $75 lower because of the greater number of low-risk individuals joining that plan. If the employer continues to charge the $190 difference between rates, it would be expected that adverse selection would continue to have about the same effect each year.

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[56] For an expected average expense of $2,100, the actuarial cost of plan A would be $1,425, calculated as 75 percent of $2,100 less the $200 deductible. The actuarial cost of plan B would be $1,615 with the 85 percent coinsurance. The difference is $190.

TABLE 6.3. Effect of Choice in First Year of Program

Group and plan	Average benefits	Number	Total benefits
Risk group I			
In plan A	$1,050	600	$ 630,000
In plan B	1,190	400	476,000
Risk group II			
In plan A	$1,800	400	$ 720,000
In plan B	2,040	600	1,224,000
Total	$1,525	2,000	$3,050,000
Summary by Plan			
Plan A	$1,350	1,000	$1,350,000
Plan B	1,700	1,000	1,700,000
Total	$1,525	2,000	$3,050,000

The adverse selection demonstrated in this example does not have a major impact on the total cost of the health benefits for both groups combined. The total cost in a single plan (with no adverse selection) would have been $3,040,000. Because under the choice design enrollees are allowed to move to a more generous plan than in the single plan design, the total cost (with adverse selection) is only .3 percent greater, for a total of $3,050,000.

The FEHBP approach to setting rates for enrollees has a much different effect. If the employer were to pay 60 percent of the average of the cost of the options, the rates in the first year, after the first open season, would be determined as shown in table 6.4.

TABLE 6.4. Cost in the First Year with FEHBP Rate Setting

	Plan A	Plan B
Total cost	$1,350	$1,700
Employer share	915	915
Enrollee share	435	785
Enrollee share as % of total	32%	46%

The result is that the enrollee would pay the total cost of the benefit difference plus the effect of adverse selection.[57] In the second open season, many of the enrollees in plan B would choose the lower cost plan A. It would be expected that proportionately more of the transfers would come from low risk group I.

Table 6.5 shows the effect of transfers during the second open season under the FEHBP approach. The actual cost differential between plan B and plan A has risen from $350 to $516. Since the Government's share of the premium is the same fixed amount for each plan, the difference between plans in the enrollee's rate is widened, and more enrollees would move from plan B to plan A in the third open season. This adverse selection spiral might continue until all plan B members were from high risk group II, with an average cost of $2,040.

Table 6.5 also shows how choice may actually reduce overall costs in certain situations. If the higher benefit plan (plan B) becomes so expensive that even many of the high-risk enrollees move to plan A, then choice could actually lower cost. Without choice, all members would be in the single plan. With choice, followed by extensive adverse selection, most enrollees would choose the lower cost plan, offsetting the cost of selection by the few who remained in the higher cost plan.

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[57] In fact, under the FEHBP approach, the difference in cost would be greater than the difference in actuarial value even in the first year. The actuaries for the two plans would set a wider difference in the rates in anticipation of some degree of adverse selection. To highlight the operations of the rate setting for enrollees, the illustration ignores inflation in the second and third year as well as the ability of actuaries to predict the effect of shifts. Introducing these aspects would show the same relative results.

TABLE 6.5. Effect of Choice in Second Year with FEHBP Rate Setting

Group and plan	Average benefits	Number	Total benefits
Risk group I			
In plan A	$1,050	850	$ 892,500
In plan B	1,190	150	178,500
Risk group II			
In plan A	$1,800	500	$ 900,000
In plan B	2,040	500	1,020,000
Total	$1,496	2,000	$2,991,000

Summary by Plan

Plan A	$1,328	1,350	$1,792,500
Plan B	1,844	650	1,198,500
Total	$1,496	2,000	$2,991,000

Table 6.6 shows the calculation of the enrollee share based on the second year of experience. In the second year, the enrollee cost for plan B is $516 over that for plan A, an increase over the first year differential of $350. As a result, there would be further shifting to plan A in the third open season. Table 6.7 summarizes the enrollee premium for each of the three open seasons. The initial actuarial difference of $190 increased to $350 after the results of the first open season, and to $516 after the results of the second open season.

TABLE 6.6. Cost in the Second Year with FEHBP Rate Setting

	Plan A	Plan B
Total cost	$1,328	$1,844
Employer share	952	952
Enrollee share	376	892
Enrollee share as % of total	28%	48%

TABLE 6.7. Enrollee Rates in First Three Years with FEHBP Rate Setting

	Plan A	Plan B	Difference
First open season	$513	$703	$190
Second open season	435	785	350
Third open season	376	892	516

Chart 6.1 shows the changes in the total premium in the first three years of operation in this illustration if the results of inflation are ignored. The first set of bars shows the actuarial difference of $190 a year before any selection takes place. The second set show the difference ($350) after the first round of selection, and the third set show the difference ($516) after the second round of selection. The difference will continue to widen as long as adverse selection continues to drive more enrollees from plan B to plan A.

CHART 6.1. Impact of Choice on Total Premium

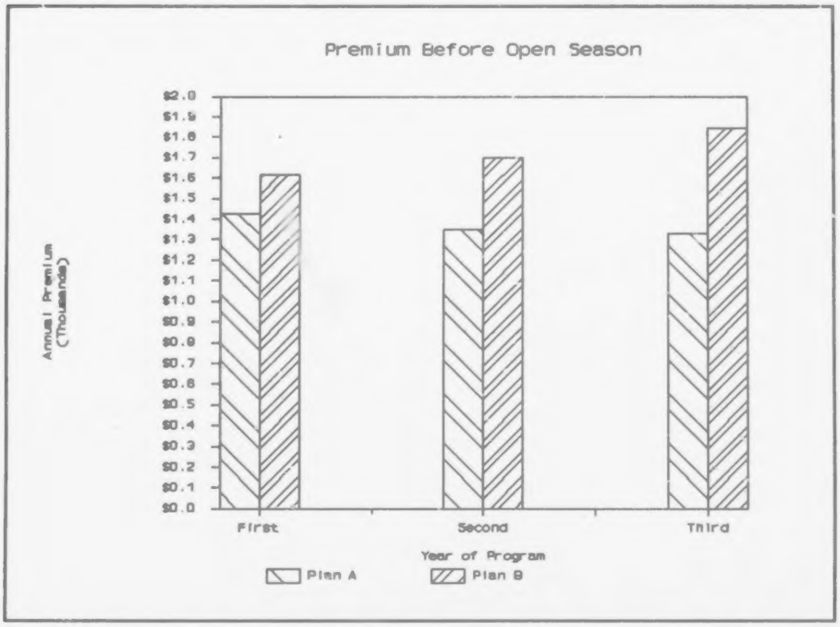

Chart 6.2 shows the changes in the premium to the enrollee if the private sector approach were used. The difference in premium each year remains at the $190 difference in actuarial cost. Since the effects of inflation are not shown, and the total cost of the program is only slightly affected by adverse selection, the enrollee premiums do not vary significantly from year to year.

CHART 6.2. Impact of Choice on Enrollee Share of Premium, Private Sector Method

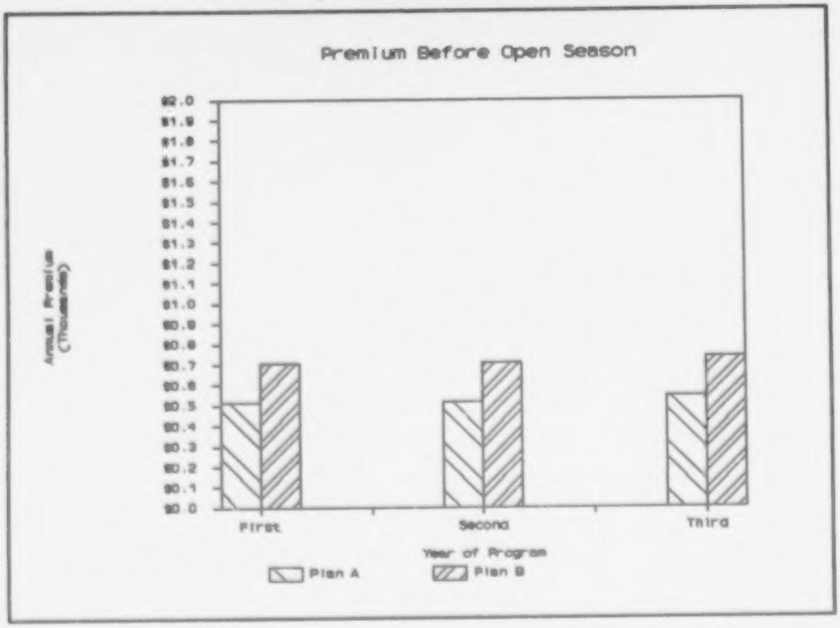

Chart 6.3 shows the enrollee premiums if they were determined by the FEHBP rate-setting method. Since all but a small part of the cost of adverse selection would be passed to the enrollee,[58] the difference in the enrollee share of the premiums shown in chart 6.3 is the same as the difference in total premiums shown in chart 6.1. The percentage difference in enrollee premiums is, however, much wider than the relative difference in total premiums. This widening difference will in turn create further adverse selection and even wider differences in the premium.

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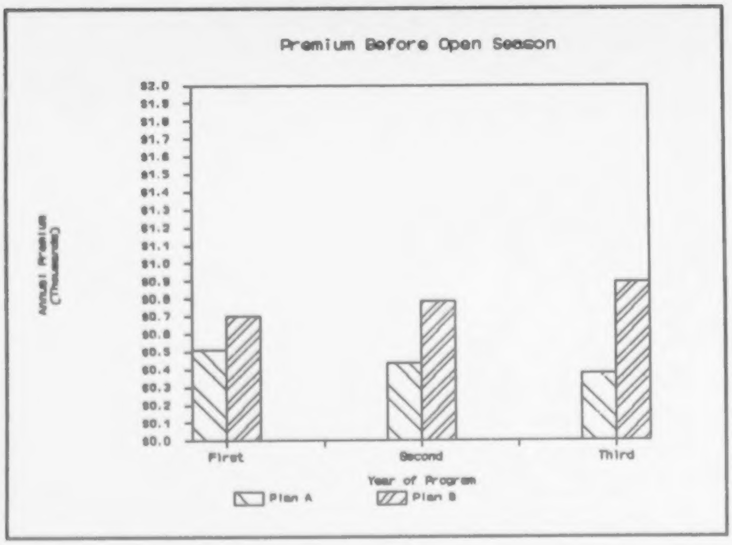
[58] In this illustration, the Government is assumed to pay 60 percent of the unweighted average of the premiums. This average goes up by $5 in the second year so the Government rate increases by $3. In the third year, the Government rate goes down slightly. In the much more complex FEHBP, the Government cost is affected by adverse selection since the rate is tied to the premiums of six specific plans.

CHART 6.3. Impact of Choice on Enrollee Share of Premium, FEHBP Method



There are four important differences between choice plans in the private sector and choice as it is structured in FEHBP:

- Private-sector plans usually have five or fewer FFS choices compared to the 21 or more available to all employees in FEHBP in 1989.

- Private sector FFS health insurance options are typically self insured or provided by the same insurer. Therefore, enrollees in the private sector can focus on the benefit differences without being concerned about possible differences in the administrative and cost control practices of different insurers. The differences between insurers are, in fact, nominal and are not part of the decision as they appear to be in FEHBP.

- Private sector plan premium differences are generally tied to the actuarial differences between the options. Unless an employer has a reason to influence enrollees' selection of a particular option, the enrollee's premium share does not reflect the effect of selection. In FEHBP, the rate-setting method requires some enrollees to pay most of, and enables others to benefit from, the cost of adverse selection by others.

- In the typical private sector plans, all options provide the same basic protection against major health care expenses. While the FEHBP options are close to each other in overall design, some options have gaps in coverage that could result in major additional costs for enrollees selecting those options.

C. Choice in FEHBP

Choice has been a feature of FEHBP since its first year of operation. However, the design of the choice as encoded in the law and OPM regulations does not permit FEHBP to achieve some of the advantages that are found in private sector choice plans. In some respects, the FEHBP design actually creates problems.

In 1989, FEHBP offers approximately 450 FFS and HMO options. However, each Federal enrollee and annuitant is eligible for only a small number of these plans. Most of the plans are HMOs that can be selected only by enrollees in their geographical service areas.

Nevertheless, the choices open to Federal enrollees are much greater than in the private sector, even for employers who offered a choice of FFS options. For 1989, each Federal enrollee could choose among the 21 options open to all Government enrollees and annuitants. Enrollees in specific organizations or who worked in specific areas could choose one or two other options. The number of HMOs available to enrollees ranged from zero in some areas to as many as 15 in areas, such as California, with a large number of HMOs. Within broad limits set by OPM, the FFS and HMO plans have the freedom to design plans and determine access to providers to compete for enrollee participation.

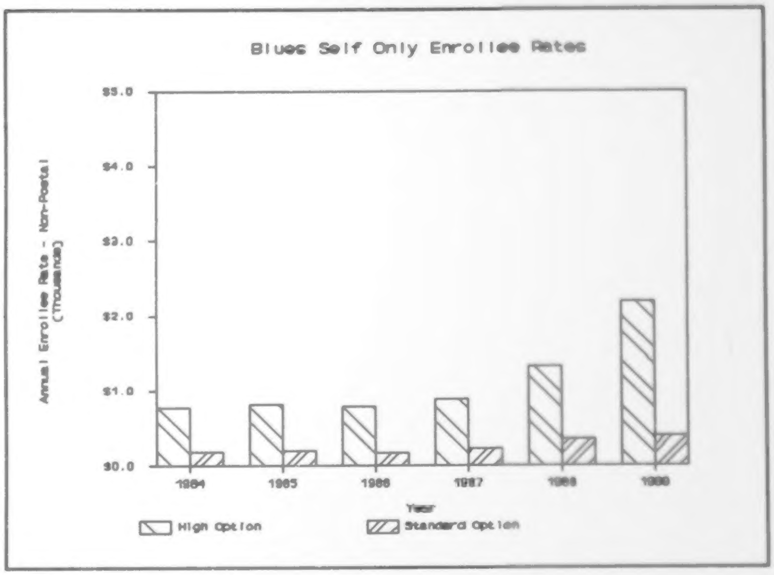
1. Effect of Choice in FEHBP

The previous illustration showed the theoretical effects of choice. The illustrative group of employees could have chosen between two plans. Adverse selection by the enrollees increased the rate difference that would have resulted from the actuarial difference alone. If the enrollee rates had been set using the FEHBP approach, the difference in cost would have been paid by the enrollees, thereby leading to larger differences and more adverse selection. However, the total cost of the program would not have been significantly changed.

While FEHBP, with its approximately 450 options, is much more complex, the same effects can be seen by comparison on a plan-by-plan basis. The clearest example of the shifting of cost between plans can be seen by comparing Blue Cross High Option with Blue Cross Standard Option. In 1989, the two BC options have almost the same actuarial value. If there were no adverse selection, the two options would therefore cost about the same. However, over the years the High Option has become the choice of those with highest expenses and the Standard Option has attracted an average group of risks.

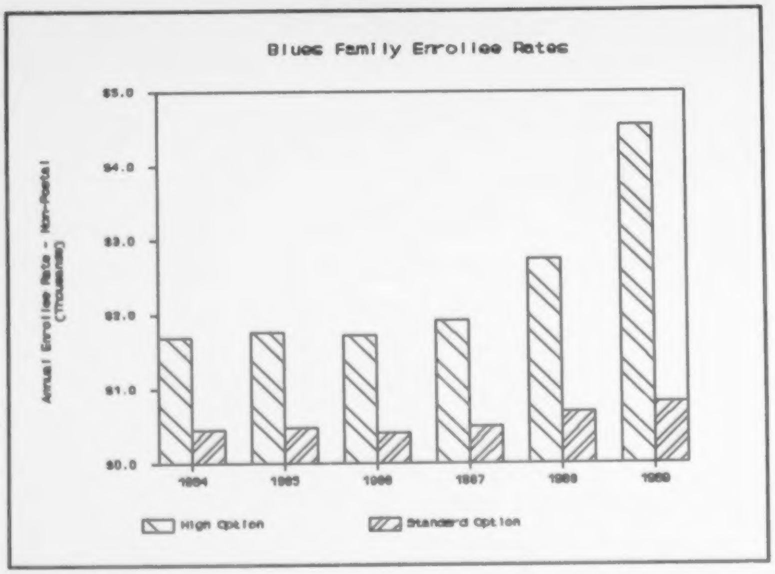
Charts 6.4 and 6.5 compare the annual premiums paid by nonpostal enrollees for the two Blues options from 1984 through 1989. Adverse selection had already created a substantial premium difference by 1984, and from 1987 to 1989, the premium difference widened rapidly. At each open season, more than a third of the enrollees leave High Option, with most of those transferring to Standard Option.

CHART 6.4. Annual Nonpostal Enrollee Premium Rates, 1984-1989



Source: OPM Enrollment Information Guide and Plan Comparison Charts, 1984-1988.

CHART 6.5. Annual Nonpostal Enrollee Rates, 1984-1989



Source: OPM Enrollment Information Guide and Plan Comparison Charts, 1984-1988.

Comparing charts 6.6 and 6.7 shows the effect of adverse selection among nine FEHBP options.[59] The actuarial benefit values of the nine options vary by no more than 35 percent, but the total premium for the highest cost plan is 246 percent greater than that of the lowest cost plan.[60]

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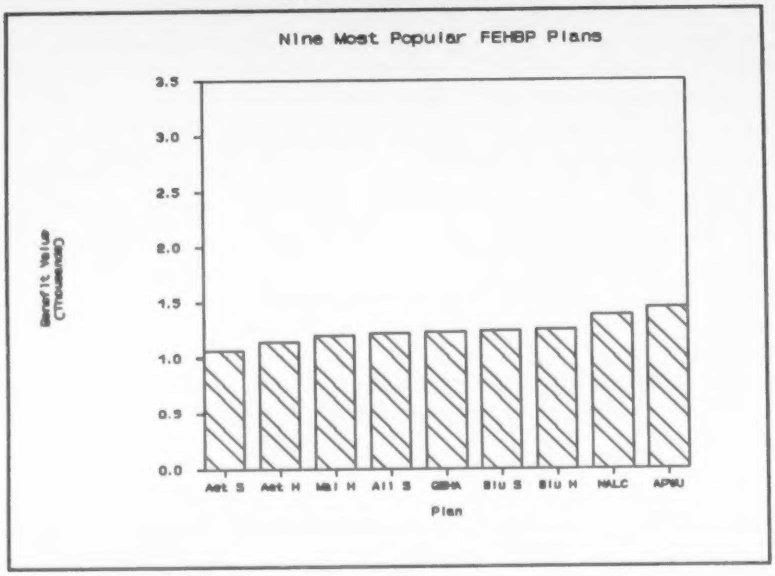
[59] These nine were chosen from among the FEHBP options that are open to all enrollees and annuitants. They are the nine such options with the highest enrollment.

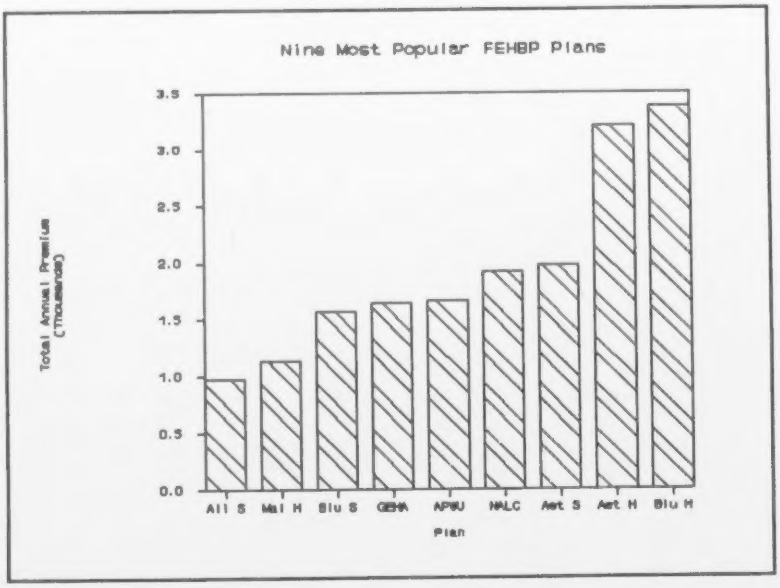
[60] The actuarial benefit values shown in charts 6.6 and 6.8 are not adjusted for standard Federal demographics.

CHART 6.6. Relative Benefit Value in 1989
($ in thousands)



Source: FEHBP Model.

CHART 6.7. Total Annual Premiums in 1989
($ in thousands)

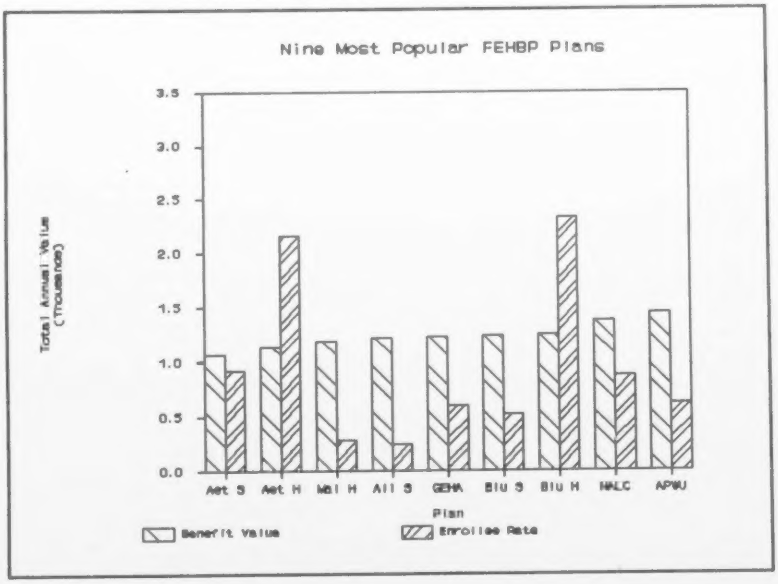


Source: OPM Enrollment Information Guide and Plan Comparison Charts, 1988.

Chart 6.8 compares the actuarial benefit values to the share of the premium paid by the enrollee in each option.[61] Enrollees have the choice of selecting options that will minimize their risk of paying medical expenses out-of-pocket. However, FEHBP's method of determining the enrollee premium places almost the entire burden of adverse selection costs on the enrollee. As a result, the additional cost of the better protection is much greater than the additional actuarial cost of the better benefits.

Since the Government pays a large portion of the cost, enrollees would expect to receive more in benefits than they pay in premiums. This relationship is true for the average enrollee in most plans. For instance, the enrollees in Blue Cross Standard Option receive an average of $1,241 in benefits for $525 in premium. However, in the highest cost plans, the average enrollee would pay much more in premiums than the value of benefits. The average enrollee would receive benefits of $1,245 in Blue Cross High Option in return for a premium payment of $2,332.

CHART 6.8. Benefit Value Compared to Enrollee Premium Cost, 1989



Source: FEHBP Model and OPM published premium data, 1988.

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[61] The actuarial benefit values shown in chart 6.8 are not adjusted for standard Federal demographics.

2. *FEHBP's Approach to Premiums for Different Options*

Since FEHBP permits more choices and does not have standard benefits across all plans for major types of medical expenses, the effect of choice is much different from that illustrated in the prior section. The degree of difference can be shown by considering an illustrative selection among three options by four risk groups. Table 6.8 shows three options that are made available to a group of 1,000 enrollees. The options vary in coinsurance from 75 percent to 85 percent, and the maximum out-of-pocket limit varies from no limit to $1,000. Before the choice was given, all enrollees had to be in option B.

TABLE 6.8. Design of Plan Choices

	Plan A	Plan B	Plan C
Deductible	$200	$200	$200
Coinsurance	75%	80%	85%
Maximum out-of-pocket	None[a]	$3,000	$1,000

[a] All options in FEHBP have a maximum out-of-pocket limit, but the limit does not always cover all expenses.

Table 6.9 shows the distribution of medical expenses within the group of enrollees. The 1,000 enrollees are split into four risk groups ranging from those with no expenses to those with very high expenses. It is assumed that 150 enrollees would have no expenses, 600 would have modest bills averaging $600, 230 would have a short hospital stay with an average bill of $3,000, and 20 would have very high expenses averaging $25,000.

If only option B were available, the average benefit would be the $1,147 shown in table 6.9 by applying the option B cost-sharing factors to each risk group. Table 6.10 shows the effect on individual and total benefits if enrollees were free to choose among the three plans and if there were a strong degree of adverse selection.[62]

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[62] The illustration does not include administrative costs, reserve effects or the interaction of plan design and utilization. These factors would complicate the presentation and not improve the validity of the presentation. Therefore, the cost of the premium is identical to the cost of the benefit.

TABLE 6.9. Cost If All in Plan B

	Average expenses	Number	Total expenses
Risk group I	$ 0	150	$ 0
Risk group II	600	600	360,000
Risk group III	3,000	230	690,000
Risk group IV	25,000	20	500,000
Total	$ 1,550	1,000	$1,550,000

	Average expenses	Benefit	Total benefit
Risk group I	$ 0	$ 0	$ 0
Risk group II	600	320	192,000
Risk group III	3,000	2,240	515,200
Risk group IV	25,000	22,000	440,000
Total	$ 1,550	$ 1,147	$1,147,200

TABLE 6.10. Cost If Employees Can Choose Among Plans A, B, and C

	Average Benefit	Number selecting	Total benefit
Risk group I			
In plan A	0	80	0
In plan B	0	40	0
In plan C	0	30	0
Risk group II			
In plan A	$ 300	200	$ 60,000
In plan B	320	200	64,000
In plan C	340	200	68,000
Group III			
In plan A	$ 2,100	50	$ 105,000
In plan B	2,240	80	179,200
In plan C	2,380	100	238,000
Group IV			
In plan A	$18,600	2	$ 37,200
In plan B	22,000	7	154,000
In plan C	24,000	11	264,000
Total	$ 1,169	1,000	$1,169,400
Average Benefit by Option			
In plan A	$ 609	332	$ 202,200
In plan B	1,215	327	397,200
In plan C	1,672	341	570,000
Total	$1,169	1,000	$1,169,400

The adverse selection would have little effect on the total group benefit. The average benefit would increase from $1,147 a year if all enrollees were in plan B to $1,169 a year under the three-option illustration. This 2 percent increase occurs because enrollees with higher expenses move to plans with better coinsurance and out-of-pocket limits.

The illustration assumes that many enrollees can predict the risk group they will be in and select the appropriate option. The illustration also includes an assumption that, even in the face of perfect knowledge, some enrollees will not make the least costly decision. As is the case in FEHBP, many enrollees with low expenses will join the plans with better cost sharing.

Conversely, many enrollees with high expenses will join a plan that provides low levels of coverage. However, the divergence of premium cost among FEHBP plans clearly shows that many enrollees do select the plan that offers them the best economic return.

The assumption in this example is that over half of the enrollees who anticipate no expense would select the lowest benefit plan. Those in risk group II would choose randomly since there is little to be gained among the three benefit structures. Most of those in risk group III are assumed to select plan C because benefits would be $170 greater than in plan A. Over half of those in the highest risk category would choose plan C since benefits would be $5,400 higher than in plan A and $2,000 greater than in plan B.

The illustration assumes that the employer would charge employees premium amounts in the first year of the program based on the actuarial equivalent value of each plan's benefits. In a plan like FEHBP, after the first year, the employer would set the premium based on the actual utilization of those who select each option.

Assume, for instance, that the employer contributes toward each plan an amount equal to 60 percent of the unweighted average cost of the three plans but no more than 75 percent of each rate (the current FEHBP rate-setting formula). The employer contribution would then be $701 (60 percent of $1,169) for plans B and C, but would be only $457 (75 percent of the $609 cost) for plan A:

TABLE 6.11. Determination of Annual Enrollee Rate

Plan	Total rate	Employer rate	Enrollee rate
A	$ 609	$457	$152
B	$1,215	$701	$514
C	$1,672	$701	$971

As a result, the difference in enrollee rates between plan C and plan A would be three-fourths of the difference in total rates between plans C and A. Since all but a small part of this difference is a result of adverse selection among those who select option C over the other two options, the enrollee is paying a much higher rate because he or she happens to be in the group with the worst risks.

The large difference in enrollee rates in the second year would drive more of the better risks into options A and B, thereby increasing the rate difference. This in turn would lead to higher rate differences and more adverse selection in the third year.

The ultimate outcome would be that only those in risk group IV would be in plan C. By that time the total rate would be close to the $24,000 average benefit expense for risk group IV, an amount that would deter other participants from buying the better protection. It is very likely, however, that the employer would have closed down plan C as being too expensive long before only risk group IV enrollees were left in plan C. The result would be that enrollees who wanted the plan C design would find that it was no longer available.

Rising premium costs due to adverse selection may also lead enrollees to choose lower cost plans that expose them to greater risk of out-of-pocket expenses. Out-of-pocket costs for enrollees in option B are limited to $3,000 a year.[63] High-risk enrollees would be inclined to choose option C with its limit of $1,000. If, however, an enrollee in good health were to choose plan A, and then be involved in a serious accident, there would be no limit on his out-of-pocket expenses. The two enrollees with a $25,000 expense who chose option A would have out-of-pocket medical expenses of $6,400[64] rather than the $1,000 limit if they had selected plan C.

3. FEHBP from the Enrollee's Perspective

FEHBP offers a wide range of choice among alternate benefit designs and delivery systems. The annual FEHBP deductibles for FFS plans range from $150 to $750 and maximum out-of-pocket limits on most health care costs range from $750 to $3,000. Some plans emphasize coverage of inpatient care by paying in full for such expenses. Other plans charge coinsurance on all care, including inpatient care. Enrollees can select plans with widely different levels of coverage for dental care, prescription drugs, chiropractic and extended-care facilities.

There is a particularly wide range of selection in mental health care coverage. All FFS plans cover inpatient mental health care, but the out-of-pocket limit on covered expenses ranges from $1,500 to $8,000. And there is a lifetime maximum on these expenses ranging from $25,000 to $75,000.

While the range of choice is wide, adverse selection in FEHBP and the formula for determining the enrollee share have resulted in two problems for the enrollee:

- A difference in premiums among the options that is much greater than the difference in actuarial value.

- A possibly open-ended exposure to risk that would not occur if there were one plan that covered all expenses with a maximum limit on the enrollee's out-of-pocket expenses, or no plan with an open-ended risk exposure.

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[63] This assumes that all health care expenses are covered by the plan and are within the R&C maximums.

[64] The $200 deductible plus 25 percent of the remaining $24,800 of the expenses.

Enrollees can usually find the benefits they want among the FEHBP options, but adverse selection may have raised the cost higher than the enrollee may wish to pay. For instance, the lifetime maximum on inpatient mental health care ranges from $25,000 to $75,000, but the higher coverage is available only to those who choose to join the most expensive option.

All FEHBP plans have out-of-pocket maximums. Even so, enrollees may find that they have to pay substantial out-of-pocket costs because the out-of-pocket maximum does not fully cover all types of health care expenses. There are several ways in which an enrollee may be exposed to significant and unexpected out-of-pocket expenses.

First, a category of benefits may simply not be covered. For instance, some of the plans do not cover prescription drugs outside of the hospital. While most individuals think in terms of a $10 to $20 prescription drug cost, in today's environment of immunosuppressants and AZT drug therapies, the cost of prescriptions can run into thousands of dollars per year.

Second, plans may use methods to limit the amount of the provider's charge that they will reimburse. For example, a plan may use a surgical schedule, paying a fixed amount for a surgical procedure that could be considerably lower than the typical charge for that procedure in a high cost metropolitan area.

Third, plans may not count certain expenses toward the out-of-pocket limit. One example is inpatient mental health costs. A patient suffering from an acute eating disorder may face mental health hospital and physician costs of $50,000 or more. The coverage provided by FEHBP plans can vary by as much as $25,000.

Table 6.12 shows the percentage of enrollees who transferred out of the largest FEHBP plans during the 1987 open season. The "out-of-pocket difference" is the average change in enrollees' out-of-pocket costs (defined as cost-sharing amounts and premium payments) between the plan the enrollee transferred from and the plan most enrollees in that plan transferred to. The out-of-pocket amount represents the economic advantage or disadvantage to enrollees of transferring plans. The data show a correlation between the percent of enrollees leaving a plan and the out-of-pocket costs they save by doing so.

TABLE 6.12. Transfers from FFS Options During 1987 Open Season

Option	Out-of-pocket difference	Percent leaving	Enrollment before open season
APWU--Self	$ 275	2.0%	33,864
NALC--Self	-53	2.5	38,786
BC/BS---Stand./Self	-6	2.9	266,718
Mailhand--High/Self	64	4.2	81,010
Rural--Family	-356	4.6	30,024
GEHA--Self	120	4.6	47,349
NALC--Family	-33	5.5	132,865
APWU--Family	495	6.5	59,832
BC/BS--Stand./Family	175	6.8	413,536
Aetna--Stand/Self	20	7.0	60,560
Mailhand--High/Family	-143	10.3	280,438
GEHA--Family	221	12.2	189,176
BC/BS--High/Self	-748	17.0	193,443
Aetna--High/Self	-1,051	23.0	49,091
AFGE--High/Family	-752	26.8	11,467
NAPUS--Family	-510	26.9	13,563
BC/BS--High/Family	-1,651	27.9	144,976
Aetna--Stand./Family	-212	28.3	70,431
Postmasters--Family	-1,408	33.1	14,707
Aetna--High/Family	-1,425	37.0	49,647
Postal Super--Family	-485	42.5	45,543

Source: FEHBP Model, based on unpublished OPM data.

4. FEHBP from the Government's Perspective

One concern often expressed about choice in FEHBP is that it leads to higher contributions for the Government. This concern has two aspects. First, the total cost of the program may be higher because of choice. Second, the level of the Government contribution may be affected by adverse selection.

In the above examples, choice had little impact on the total cost of the health benefits plan. Since the plans were close in design, the effect of higher-risk enrollees choosing the plan with the higher cost sharing had little effect on the overall cost. FEHBP FFS plans are very close in design and actuarial value, and, therefore, it would be expected that choice would have little impact on total FEHBP costs.

The effect of choice on total FEHBP costs can be determined by calculating the difference between the actual benefits being paid under the current choice design and the benefits that would be paid if all enrollees were in a single plan. If FEHBP were replaced by a single plan with relatively low benefits the program would cost less than it does now. If, however, all enrollees were placed in a single plan with a relatively high level of benefits FEHBP would cost more than it does now.

One approach would be to assume that all enrollees would be placed in the typical FEHBP plan described in chapter 4. In that case there would be four different significant cost effects:

- An increase in program costs resulting from enrollees whose current plan has higher enrollee cost sharing than the typical FEHBP plan;
- A decrease in program costs resulting from enrollees whose current plan has lower enrollee cost sharing than the typical FEHBP plan;
- A decrease in coverage for services (such as mental health care) that are covered in full in the current plan but would be limited in the typical FEHBP plan; and
- An increase in coverage for services (such as prescription drugs) that would be covered by the typical FEHBP plan but not by the current plan.

The distributions in the FEHBP Model were used to measure the effect of moving all enrollees from their current plans to the typical FEHBP plan. The result was that the cost of FEHBP would be increased by 1 percent if all enrollees were in the typical plan. The details of the cost impact are as follows:

FEHBP cost in 1989	$11.5 billion
Net increase due to different enrollee cost-sharing formulas . . .	+0.4
Increase due to better coverage . .	+0.1
Decrease due to reduced coverage .	-0.4
FEHBP cost if all in typical FEHBP plan	$11.6 billion
Total increase in cost	+0.1 billion

Alternatively, if the single plan had the same design as BC Standard Option, the total cost of FEHBP would be lowered by 7 percent:

FEHBP cost in 1989	$11.5 billion
Decrease due to different enrollee cost-sharing formulas	-0.4
Increase due to better coverage	+0.1
Decrease due to reduced coverage	-0.5
FEHBP cost if all in typical FEHBP plan	$10.7 billion
Total decrease in cost	-0.8 billion

As is shown in this example and earlier analyses of FEHBP, choice does not have a major effect on the total cost of FEHBP. However, the interaction of choice with the current formula for determining the Government premium contribution does have a major impact on the Government's costs.

The Government contribution, within certain limits,[65] is a dollar amount equal to 60 percent of the unweighted average of the premiums of six plans in the program (this formula is known as the "Big Six"). The six are the Aetna and BC High Options; the two most popular enrollee organization plans; and the two most popular HMOs.

Using this formula, the Government contribution is higher than it would be if the formula were 60 percent of the weighted average of all plans (using the same limits). The adverse selection by high risk enrollees that has driven up the costs of the Aetna and BC High Option plans has thus increased the Government contribution and its proportion of the total premium, which is an average 71 percent in 1989.

D. Possible Changes in FEHBP that Would Affect Choice

FEHBP offers a far wider range of choice than is found in private sector employer-based plans. However, FEHBP does not have some of the features that private sector employers consider essential in their choice of plans. Changes in FEHBP, including some of the design features that are essential to private-sector plans, could improve the effect of choice on the Government and the enrollees.

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[65] The Government contribution is limited to 75 percent of the premium for any FEHBP plan. Also, collective bargaining agreements have determined that the formula for USPS employees is 75 percent of the Big Six formula, with a maximum contribution of 93.75 percent of any plan's premium.

1. *Minimum Benefits Package*

The primary purpose of insurance is to protect individuals from unexpected or catastrophic expenses. Therefore, one approach to designing a health insurance plan is to provide all enrollees with the same basic coverage that protects against these expenses. In this approach, the enrollees are not given the opportunity to choose a plan that does not contain this coverage.

All plans in the FEHBP appear to have a limit on enrollee out-of-pocket catastrophic expenses. However, the absence of coverage for some services, and limitations on the coverage of others, expose enrollees in some FEHBP plans to a high degree of risk. For instance, some plans do not cover prescription drugs and others limit the coverage of surgical procedures. In these cases, the medical expenses in excess of any limits are the responsibility of the enrollee.

FEHBP could require a minimum set of benefits that would cover all R&C (reasonable and customary) expenses after a reasonable deductible and coinsurance payments. The plan would have to provide a maximum out-of-pocket limit on these expenses.

The minimum benefit approach could be achieved either by establishing a single plan for the minimum coverage or by establishing minimum benefit requirements for all plans. Under either of these approaches, enrollees could still be offered choices of additional benefits. In the former case, the choice would be limited to supplemental options such as coverage for dental or vision care. In the later case, the enrollee could select among different options, as in the current FEHBP structure.

2. *Number of Choices*

Federal enrollees and annuitants are offered at least 21 options and, depending on their employment status and geographic location, as many as 40 options. This compares to no more than five FFS options and two or three HMOs in private sector programs with the widest choice.

The optimal range of choice in FEHBP depends on the design of choice and the degree of competition permitted. Some believe that there are too many choices in the current FEHBP to realistically expect most potential enrollees to fully understand and appreciate the differences among plans. Use of different terminology in plan brochures and comparison materials often leads the enrollee to believe that significant differences exist when they do not. On the other hand, sometimes important differences are buried in these informational materials. However, even with a much better communication effort, it is unrealistic to expect a potential enrollee to be able to select the best plan among 21 or more options.

If the range of choice is narrowed by use of minimum benefits, a meaningful understandable selection could be provided by five FFS plans.

Within the current FEHBP structure, the number of plans could be narrowed by limiting enrollee organization plans to the organization's members only.

The range of FEHBP choices could also be narrowed by limiting the number of HMOs to two or three in each geographic location. If there were more available in a location, the Government could select the best HMOs by cost, benefit and service criteria. A limit on the number of HMOs in an area would permit the Government to use the competitive process to reward efficient delivery of services and permit the enrollee to select among the types of delivery system without being faced by an overwhelming number of possible providers.

3. *Rate Structure*

The differences in enrollee premium cost among some of the FEHBP options are much greater than the differences in the actuarial value of those options. These differences occur because the effect of the adverse selection inherent in any choice program is reflected in the enrollee rates. Since the Government contributes a fixed amount[66] toward each FEHBP plan, any premium differences from plan to plan due to adverse selection costs must be borne by the enrollees. In contrast, the private sector approach to choice design is for the employer to limit the differences in enrollee premiums across plans to differences in the actuarial value of plan benefits.

In the private sector, unless the employer wants to promote or discourage a particular option, the differences in premiums due to adverse selection are charged or credited to the employer. The enrollees are charged only the actuarial difference among options. If, as in the typical private plan, the employer pays the full cost of Self Only coverage, the enrollee who selects a higher-cost option would only pay the actuarial difference. As a result, the enrollee makes a choice among plans based on rates that reflect only the relative value of the benefits, not the risk characteristics of other individuals choosing the option.

This approach might be adopted in FEHBP through one of two methods. One method that has been proposed by BC is the use of rate adjusters. Options that experienced adverse selection would be reimbursed from a fund that was built up by contributions (paid for by both the Government and the enrollees) from options that gained from favorable selection. See chapter 9 for additional information about risk adjusters.

The other approach would be to establish a basic enrollee rate for all options and to increase or decrease the rate only by differences in the actuarial benefit values of the various options.

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[66] For some plans, the Government contribution is lower than this fixed amount because of the 75 percent maximum on the Government's share.

FEHBP uses a two-rate structure (Self Only, and Family) to differentiate among family units. While this is the most common approach, there are private sector plans that set premiums according to the size and/or composition of the family unit. For instance, a plan could have different rates for a husband and wife, parent and child, two parents and one child, and two parents and more than one child.

The equity of using different family unit rate structures depends on the view of the enrollee. The two-rate structure in FEHBP is based on the assumption that the most equitable approach is to provide all family enrollees with the same coverage, regardless of family size. Structures that differentiate by family size are based on the assumption that larger families should pay more since they use more health care.

If FEHBP were a new program, each of the possible rate structures could be considered, and the most equitable implemented. Further, rate structures not commonly found, such as a single rate for all enrollees whether or not the family was covered, or an enrollee premium that was a percentage of salary, could be considered.

However, once a plan has started with one rate structure, moving to another structure presents difficult problems of equity and explanation. For example, splitting the family rate into two separate rates, one for families without children and a higher rate for families with children, might increase the cost for the larger families by 15 percent. In a year in which the average premium increased 20 percent, the larger families would be faced with a 35 percent rate increase while the two-member families would have only a 5 percent rate increase (the general increase of 20 percent, less a 15 percent reduction resulting from use of the new rate structure).

4. Encouraging and Using Competition

Competition among FEHBP plans has created adverse selection with little evidence of savings or better delivery of health care and benefits to enrollees. However, competition could be structured to focus on efficiency, meeting the goals of both the Government and the enrollees. If efficiency could be improved across the board, it would have the greatest dollar impact in areas of the largest expense. Program expenses can be broadly ranked as follows, with the most expensive first:

- Inpatient hospitalization
- Surgical
- Physician and outpatient medical expenses
- Prescription drugs
- Dental care
- Vision care

Claims expenses are 95 percent of total FEHBP expenditures, with the remaining 5 percent for administrative expenses. Consequently, competition would achieve substantial savings only if focused on more than the direct administrative expenses of the program.

Competition among providers of health care services could be fostered through alternative delivery systems. Traditional FFS plans, HMOs, PPOs, and any new health care delivery systems that might evolve could compete on the basis of cost and efficiency by varying access to health care providers.

Competition among administrative services organizations could be obtained in a variety of ways. FFS plan administrators could compete to provide claims payment services, utilization review, and provider negotiations. Improvements in administration will often result in increased administrative costs. However, well-designed administrative changes could achieve higher savings through reductions in direct claims costs.

Effective use of competition would require a substantial effort by the Federal Government in monitoring the activities of and results achieved by each competitor. Without close controls, competitors could design services and administrative procedures designed to attract the better risks and achieve lower costs for that reason alone.

5. *Self Insurance*

Large private sector employers typically self insure their programs. Self insurance could facilitate the design of the choices and setting of rates. If the program were self insured, there would be one risk pool covering all enrollees. There would not be any need to set up financial transactions among different carriers to offset the effect of adverse selection. Enrollee rates could be set according to differences in the actuarial value of benefits and not as a function of an overall rate that was affected by risk selection.

6. *Communication*

The key to enabling enrollees to use choice to their best advantage is adequate knowledge of the effects of choice. That knowledge is best achieved through a good communication program. OPM attempts to reach each enrollee with open season information, but the success of that effort is limited by the extent and complexity of the choices and the limited funds budgeted for communication.

As pointed out earlier, the range of difference between plans is more apparent than real. The open season material appears to present 21 to 40 distinct choices to each enrollee, but the benefit packages offered by many of the options are almost identical. An intensive communication effort, coupled with more consistency in option design and definitions, should clarify the differences among the options. The result of the current situation is that many enrollees do not make the optimal choice, given their probable need for medical care. A choice that should be viewed as an enrollee benefit is often seen as more of a burden.

The changes described above could facilitate communication. That is, if all options were self insured, minimum benefits were required, the number of options were reduced, and premiums were based on actuarial differences, it could be much easier to identify and communicate the range and effect of choice.

Even for such a streamlined program, however, good communication would require a larger expenditure of funds. Well in advance of the open season, every potential enrollee could receive a complete package describing all plans. Communication approaches now being used in the private sector could be adapted to clearly explain the choice not only to enrollees who work in central offices, but also to enrollees in isolated installations and annuitants. Examples of private sector communication approaches include computer programs to help prospective enrollees understand plan costs and benefits, and employer-sponsored lectures on the health plan.

OPM reviews and approves the carrier brochures, but the methods carriers use to publicize their options are not subject to any review. Some believe that better communication would occur if all materials were prepared and distributed by the Government.

In theory, open seasons could be held less frequently. However, this could mean that benefits and rates would be fixed for more than a year, an unlikely possibility with rising costs and the current method of setting enrollee rates. If some of the above changes were made, such as a move to self insurance and decoupling of enrollee rates from plan experience, less frequent open seasons could be part of the change.

CHAPTER 7. THE TREATMENT OF ANNUITANTS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

A. Introduction

Because of their special circumstances and relatively large numbers in FEHBP, Federal annuitants--people receiving Federal civil service retirement, disability, and survivor annuities--warrant special attention. On the whole, annuitants have much higher medical expenses than active workers, and thus have a broad influence on the rate and benefit structure of the FEHBP plans. In addition, many of them are entitled to Medicare, which, while reducing FEHBP costs, complicates the coordination of benefits between the two programs and raises problems of duplicative coverage and questions of equitable treatment.

1. Major Issues

Issues concerning FEHBP-enrolled annuitants vary depending on whether or not they are covered by Medicare. Medicare pays the bulk of the medical bills for annuitants insured under both programs, yet they pay the same premiums as everyone else in their FEHBP plan. This arrangement raises the questions of whether annuitants with Medicare as a group "subsidize" other FEHBP enrollees, and whether they are receiving a "fair deal" from the program. Also, the recent addition of catastrophic coverage under Medicare has intensified interest in seeking ways to adjust FEHBP benefits and premiums to take account of duplicative coverage. For example, one approach would provide to annuitants "medigap" policies (which would supplement Medicare's benefits) rather than the more comprehensive and relatively expensive benefit packages currently offered under FEHBP.

Because on the whole annuitants without Medicare have the highest costs to FEHBP, they tend to drive up the costs of the plans in which they enroll. To minimize the risk selection that this engenders, some analysts have advocated that annuitants without Medicare, or all annuitants, be put in a separate risk pool, as is sometimes done in the private sector.

Another issue is whether the costs to the Government of providing health insurance to annuitants could be reduced if it purchased Medicare for annuitants otherwise ineligible for its benefits. For example, would the savings to FEHBP (from having Medicare be the primary payer of most medical expenses) be larger than the costs to the Government of purchasing Medicare coverage for them, or would such an action merely shift costs from one Government program to another?

2. Major Findings

- Annuitants without Medicare drive up the costs of the plans in which they enroll.

- Because annuitants with Medicare as a group cost FEHBP less than workers and annuitants without Medicare, they lower the premiums of other participants in FEHBP.

- On the whole, FEHBP provides higher benefits for annuitants with Medicare than they could purchase commercially with what they pay in premiums.

- Many annuitants entitled to Medicare do not choose lower-cost FEHBP plans, even though it is to their economic advantage to do so.

- By and large, the private sector provides less health-benefits coverage for retirees, but usually at no premium cost to the retiree.

B. Background

Annuitants comprise a very large share of FEHBP participants, especially compared to private sector plans. In 1989, of 4.0 million FEHBP enrollees, 1.5 million (38 percent) are annuitants. An additional half million annuitants are not enrolled in FEHBP. About 45 percent of nonenrolled annuitants waived FEHBP coverage--many of them presumably are in some other medical plan (e.g., a spouse's plan, another employer's plan, a private policy etc.)--and the rest are ineligible. There are estimated to be approximately 400,000 dependents of annuitants covered under FEHBP.

TABLE 7.1. Annuitants' Share of Overall FEHBP Enrollment, 1989

Total population enrolled in FEHBP	Active workers		Annuitants	
	w/FEHBP	w/o FEHBP	w/FEHBP	w/o FEHBP
4,013,000	2,481,000	450,000	1,532,000	500,000

Source: FEHBP Model estimates based upon 1988 OPM data.

1. *Basic Treatment of Federal Annuitants under FEHBP*

Annuitants enroll in FEHBP under the same coverage options (i.e., for Self Only or Family coverage), have the same annual open season (and ability to change elections at other times due to other circumstances, e.g., death of a spouse), pay the same premiums and, except for those with Medicare, receive the same benefits, as active workers. They are included in the same risk pools as are workers enrolled in the various FEHBP plans. For most, FEHBP premiums are deducted from their Federal annuity checks. To enroll, an annuitant must have participated in FEHBP (1) during the 5 consecutive years before retirement, or (2) for all service since their first opportunity to enroll. Annuitants who cancel their FEHBP coverage cannot later reenroll in the program.

2. *Treatment of Federal Annuitants with Medicare*

a. Medicare Parts A and B. Federal workers earn eligibility for Hospital Insurance (HI, or Part A of Medicare) either by working in employment covered by the HI portion of the social security payroll tax (as of 1983 virtually all Federal employment became covered) or as a spouse of someone who earns such coverage. When an "insured" person reaches age 65 or meets the social security disability criteria for a requisite period of time, his or her eligibility for HI begins. In addition, all residents of the U.S. may elect Supplementary Medical Insurance (SMI, or Part B of Medicare), which provides benefits for physicians' and other outpatient services. Part B requires payment of a premium from the recipient. Beginning in 1989, persons eligible for Medicare also receive catastrophic coverage protection, financed from an increase in the Part B premium and a new supplemental premium based on income tax liability.

It is estimated that about 51 percent of Federal annuitants enrolled in FEHBP have Medicare Part A protection. Of the 1.0 million annuitants over age 64, 73 percent are eligible for Medicare Part A. The bulk of nonmedicare-covered annuitants (63 percent) are ineligible because they are under age 65 and not disabled.[67]

Except for differences in the way supplemental premiums for Medicare catastrophic coverage are calculated (see below), FEHBP annuitants are treated the same under Medicare as are all other Medicare beneficiaries. However, because most medical services are covered by both programs, Medicare and FEHBP coordinate their benefit payments (as almost all forms of insurance do) to ensure that the enrollee is not paid twice for the same service.

By law, the Medicare program is the "primary payer" for annuitants who are entitled to that program (unless they are still employed). This means that Medicare pays for most hospital and/or physician services. In addition, OPM requires that each plan participating in FEHBP waive its hospital and/or medical deductibles and coinsurance (HMOs generally have small deductibles and copayments) for enrollees entitled to Medicare. Thus, FEHBP annuitants with Medicare have virtually 100 percent coverage for hospital and doctor bills. However, coverage for prescription drugs, dental and mental health, and other categories of health care with limited payments by Medicare and/or FEHBP plans can vary, and annuitants are liable for charges that neither Medicare nor FEHBP covers.

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[67] Unpublished OPM data. The OPM data classify Medicare annuitants as those with Part A only, or Part A plus Part B eligibility. Those with just Part B eligibility are not included.

Because it pays for most of the medical bills of those covered by both programs, Medicare reduces the cost of annuitants' participation in FEHBP. As a result, some FEHBP enrollees with Medicare complain that they are providing a subsidy for other enrollees (workers and annuitants without Medicare).

b. Medicare Catastrophic Health Insurance. The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) established an upper limit on beneficiary liability for Part B Medicare-covered services, expanded certain benefits, and added new benefits. Like many other people eligible for Medicare, FEHBP enrollees with Medicare will be required to pay new premiums for this coverage. One is a surtax on Federal income tax liabilities of people who are eligible for Part A of Medicare (HI) or who would be eligible if they applied. The other is an add-on to the monthly flat rate premium paid by Part B enrollees. In 1989, the income-related premium, at $22.50 per each $150 of tax liability, represents a 15 percent surtax, up to a maximum of $800 for a single person ($1,600 for a couple filing jointly).[68] In addition, for those enrolled in Part B of Medicare, $4.00 is added to the monthly premium of $27.90 in 1989 for catastrophic coverage.

The catastrophic coverage law provides that the surtax rate will rise progressively to 28 percent over the 1989-1993 period, with the maximum premium in 1993 reaching $1,050 for an individual and $2,100 for a couple filing jointly. After 1993, the surtax rate (and the maximums) will be set annually at a level sufficient to keep the new receipts growing at the same rate as the costs of the catastrophic benefits. The flat-rate add-on to the Part B premium will grow to $10.20 by 1993, after which it too will be set to keep receipts in line with the costs of the program. When the law was enacted, it was anticipated that 63 percent of the financing of the new benefits would come from the surtax premiums and 37 percent from the flat-rate premiums.

Although the new coverage may provide additional coverage for annuitants enrolled in the few FEHBP plans that have significant gaps in their catastrophic coverage, it probably will have little effect on the benefits of most FEHBP enrollees. While Medicare will pay for more medical expenses than it did before, many of these expenses would have been paid by the FEHBP, so to a large extent the new catastrophic coverage merely shifts costs from one Government program to another. This was recognized when the new law was formulated, and a provision was included requiring that annuitants with Medicare receive a rebate equal to the value of those new Medicare benefits that duplicate FEHBP's. The Director of OPM announced on October 26, 1988, that the premium reduction for 1989 would be $3.10 per month for each FEHBP participant eligible for Medicare. Nevertheless, annuitants question why they have to pay the new Medicare premiums for protection they do not need because it is already provided under FEHBP.

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[68] The maximum can be as high as $3,200 for a couple filing separate returns.

4. Treatment of Federal Annuitants without Medicare

Generally, Federal annuitants without Medicare are under age 65 and have not been entitled to social security disability benefits for the requisite 24 months. As they, like other annuitants, are high users of medical care, their inclusion in FEHBP increases the overall cost of the various plans. From this perspective, FEHBP is a "good deal" for them since healthier younger workers and annuitants with Medicare can be said to subsidize their care. However, to the extent that this subsidy causes the latter groups to exercise rational choice by switching to lower-cost plans, annuitants without Medicare become a more concentrated "high-risk" group, and the premiums of the plans they choose rise rapidly.

5. Treatment of Federal Annuitants Who Work

For FEHBP annuitants with Medicare who are employed by the Federal Government, the FEHBP plan is the primary payer of benefits and Medicare is the secondary payer. For FEHBP annuitants without Medicare who work for employers other than the Federal Government, the employer's plan is the primary payer of dually covered medical bills. If the enrollee is also covered by Medicare, it becomes the secondary payer, and FEHBP the third.

C. Issues

1. Questions Concerning Cross-Subsidization

a. Do annuitants with Medicare subsidize other FEHBP participants? Because on the whole Medicare pays for most of their medical bills, Medicare-covered annuitants complain that they are paying for duplicative coverage; i.e., for coverage under FEHBP that they already get from Medicare. They argue that while they pay the same premiums as others in the program, they do not cost the FEHBP as much as other enrollees, and that they therefore are subsidizing other FEHBP participants. A corollary of this argument is that annuitants with Medicare get a "bad deal" from FEHBP; their premiums are too high for the benefits they receive.

The data do show that annuitants with Medicare cost FEHBP less than do either annuitants without Medicare or active workers. For 1989, the "pure premium"[69] averaged across all plans is $2,582 for all enrollees, but only $2,026 for annuitants with Medicare ($2,720 for enrollees without Medicare). To the extent costs for annuitants with Medicare are lower than for other groups, and this allows premiums for other participants to be lower than they otherwise would be, it can be said that their participation does provide a form of subsidy.

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[69] "Pure premium" is defined as the actual total premium charged by carriers (including both Government and employee contributions) net of all administrative expenses and reserve requirements. It is the amount of estimated claims (or benefits) paid by plans toward enrollee medical expenses, and thus represents the value (and the cost) of the plan's coverage.

TABLE 7.2. FEHBP Plan Costs as Reflected in Pure Premiums[a] for Enrollees with and without Medicare, 1989

Type of coverage	Medicare enrollees	Nonmedicare enrollees	All enrollees
Single	$1,429	$1,612	$1,563
Family	$2,623	$3,302	$3,194
Total	$2,026	$2,720	$2,582

[a] Actual premiums, net of all administrative expenses and reserves. See footnote 3.

Source: Derived from OPM data.

Whether this means that these annuitants receive a "poor deal" from FEHBP is a different matter. There are various ways to look at this issue. One is from the "insurance," rather than the "investment," perspective; that the goal of insurance is to pool risk, not to provide a favorable rate of return. Thus, it is understood to be the nature of insurance to provide "subsidies," in which participants who incur most of the risks insured against essentially receive compensation from others in the pool who do not.

A counterargument is that the "subsidy" in question does not come from healthier individuals, but from those with generally high health costs who are compensated from another form of insurance (i.e., Medicare) that they feel they have purchased separately. Since they have "paid for" their Medicare coverage, the reasoning goes, why are these benefits used to reduce the premiums of other FEHBP enrollees?

One answer to this rationale is that the provider of both FEHBP and Medicare is the Federal Government, which often structures its benefits on principles of social adequacy rather than individual equity. Although current annuitants may feel that they have "paid for" their Medicare benefits, in reality the value of the benefits far exceeds what they paid in Medicare taxes and premiums. This phenomenon is generally true for early participants in pay-as-you-go social programs, in part because in their initial years the high ratio of covered workers to recipients allows easy payment of full benefits at fairly low tax rates, but also because there is a social goal of providing "adequate" benefits that outweighs considerations of whether the benefits were "earned." As it happens, providing benefits far in excess of what contributions would dictate is even more pronounced for most Federal annuitants, because they earned Medicare eligibility through their spouse's covered employment or by being "grandfathered" into the system when Federal workers were covered in 1983. Thus, for argument's sake it would seem that the issue of whether annuitants with Medicare subsidize other enrollees in the FEHBP should take account of the inherent subsidy that current annuitants receive through the Medicare program, a subsidy provided in part by younger Federal workers currently contributing to Medicare.

As time passes, however, more and more Federal employees will work their entire career under Medicare, and therefore receive no more of a subsidy than the general population. Nevertheless, the argument that the Federal Government as the provider of both forms of insurance should integrate benefits under both programs for social adequacy reasons would still apply. An analogy would be the treatment of disabled workers who are eligible for benefits from different Government sources (social security, workers' compensation, civil service, etc.) but who have their total benefits reduced so as not to exceed certain limits.

b. Do annuitants with Medicare get their "moneysworth" from FEHBP? Another perspective on the treatment of annuitants with Medicare, and whether they "subsidize" other FEHBP participants, involves the concept of "moneysworth." In aggregate, do annuitants with Medicare pay more in premiums (i.e., what they actually pay out of pocket for their FEHBP insurance, and disregarding the Government contribution) than they receive in benefits from FEHBP? Two offsetting factors are involved in making a determination regarding this issue. One is that everyone in the FEHBP benefits from the average Government contribution of approximately 71 percent of total FEHBP costs, and this obviously reduces the premiums that everyone would pay by a roughly corresponding amount (i.e., on the whole everybody receives more than their "moneysworth"). However, the Medicare program pays for most (about 70 percent)[70] of the medical costs of annuitants insured under both programs, which obviously drives down the value of their FEHBP coverage. On the other hand, because annuitants with Medicare pay no deductibles and coinsurance, and generally have high medical expenses because of their age, their costs to FEHBP are still substantial. The key point, then, is whether the value of what are, in effect, *supplementary* benefits provided by FEHBP to annuitants with Medicare exceeds the premiums they pay.

If one accepts the reasonable assumption that the measure of the value of the benefits FEHBP provides is the cost of the pure premium discussed earlier, and if the cost of the benefits FEHBP provides to annuitants with Medicare is at least equal to the premiums they pay, then they can be said to receive their "moneysworth."

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[70] Derived from unpublished 1989 OPM data.

TABLE 7.3. Annual FEHBP Pure Premium Value Compared to Enrollee Share of Actual Premiums for Annuitants with Medicare, 1989

Type of coverage	Pure premium value[a]	Enrollee share of actual premium	Gain[b] on actual premium for Medicare enrollees
Single	$1,429	$ 807	77.2%
Family	2,623	1,352	94.0
Total	$2,026	$1,079	87.7%

[a]"Pure premium" as discussed in footnote 3.

[b]Pure premium value that exceeds enrollee share of premium.

Source: Derived from OPM data.

As table 7.2 showed earlier, the average pure premium value for all FEHBP plans is $2,582 versus $2,026 for annuitants with Medicare. Table 7.3 shows that the average *actual premium paid* by annuitants with Medicare, however, is only $1,079. The difference between the pure premium value and the actual cost to the annuitant (their share of the premium) is, of course, due almost entirely to the effect of the Government contribution. Assuming that the pure premium cost is an "actuarially appropriate" reflection of the cost of the protection afforded by FEHBP, it would appear that, *in the aggregate*, annuitants with Medicare get more than their "moneysworth," i.e., they receive more from FEHBP than they pay in premiums. Indeed, their aggregate benefits, as measured by their pure premium value, are almost double what they pay as their share of premiums. On an individual basis, however, it is possible that annuitants with Medicare can choose a plan so poorly suited to their status that they do receive on average less in benefits than they pay in premiums (see question d below).

c. *Are private "medigap" policies a better alternative*? The question of equitable treatment for annuitants with Medicare also can be addressed in terms of how the value of private policies that supplement Medicare ("medigap" policies) compares to that of FEHBP. In other words, would annuitants be better off if they withdrew from FEHBP and bought private medigap policies? The difference in the premium value versus the annuitant's share of the premium, discussed above, strongly indicates that annuitants could not purchase comparable coverage at the same cost. This point is reinforced when one considers that FEHBP plans cover preexisting conditions, an especially valuable feature for retirees, and have the economies associated with plans that are negotiated on a group rather than an individual basis.

d. *What is the effect of annuitants' choice of plans*? Part of the perception of annuitants that they get a "bad deal" from FEHBP may be due to a tendency to overinsure themselves. As mentioned, because OPM requires that FEHBP plans waive their coinsurance and deductibles for annuitants entitled to Medicare, these annuitants have virtually 100 percent coverage of hospital and doctor expenses. Therefore, it is very advantageous for annuitants with Medicare to select plans with low premiums, while disregarding deductibles and coinsurance requirements (since they are waived). However, data show that many annuitants with Medicare select plans with high premiums, for which they receive little added protection.

In 1989, it is estimated that about 203,000, or 13 percent, of FEHBP-enrolled annuitants, and about 97,000 (12 percent) of FEHBP annuitants with Medicare, are in the three most expensive plans.[71] Of the enrollees in these plans, 76 percent are annuitants, and 36 percent are annuitants with Medicare.

Only 54,000 annuitants with Medicare are enrolled in HMOs under FEHBP, compared with 67,000 annuitants without Medicare and 279,000 workers. It has been averred that one reason for the low participation of eligible annuitants in HMOs is that the comprehensive coverage of HMOs make the dual coverage of FEHBP and Medicare less attractive than it is for FFS plans.[72]

It is estimated that 48 percent of all annuitants in Blue Cross/Blue Shield (BC/BS) High Option are entitled to Medicare (65 percent of those age 65 or over have Medicare). Fifty percent of all annuitants in Aetna High Option are entitled to Medicare (62 percent of those age 65 or over have Medicare). One might think that part of this phenomenon could be ascribed to the need to provide high coverage to a spouse not entitled to Medicare, but annuitants who elected Self Only coverage show the same pattern (49 percent of the Self Only in BC/BS High Option are entitled to Medicare--and 63 percent of those age 65 and over).

These data make it appear that many annuitants do not make the allowance they should for the effect of Medicare coverage. Logically, when Medicare becomes the primary payer of benefits most annuitants would be better off in low-cost plans, yet there is not the large change that one might intuitively expect in the average premium annuitants pay as they attain age 65, when 73 percent of them become eligible for Medicare. This phenomenon is illustrated in the following table:

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[71] These plans have premiums at least 90 percent higher than the average of all FEHBP plans.

[72] Welch, W. Pete. *Restructuring the Federal Employees Health Benefits Program: The Private Sector Option.* Working Paper No. 2218-02. Washington, Urban Institute, Jan. 1989. p. 21.

TABLE 7.4. Average FEHBP Premiums Paid by Annuitants by Age, 1988

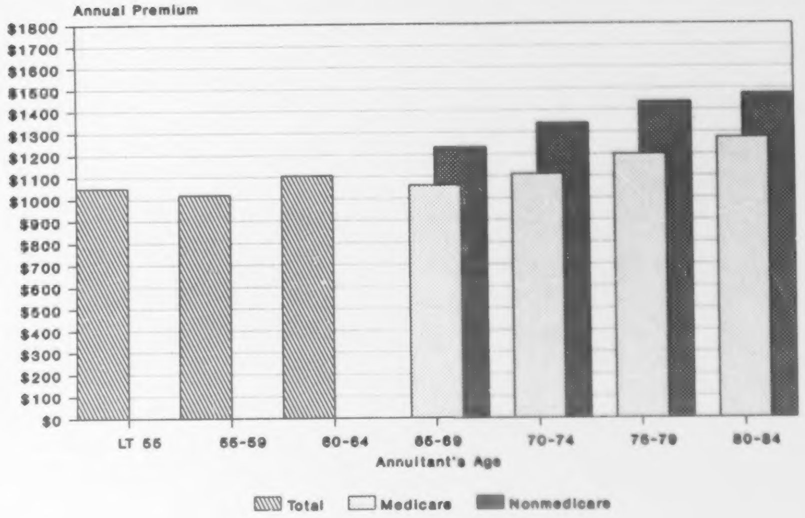
Age	Average yearly premium
55-59	$ 898.00
60-64	962.00
65-69	937.00
70-74	969.00
75-79	1,023.00
80-84	1,036.00

Source: FEHBP Model.

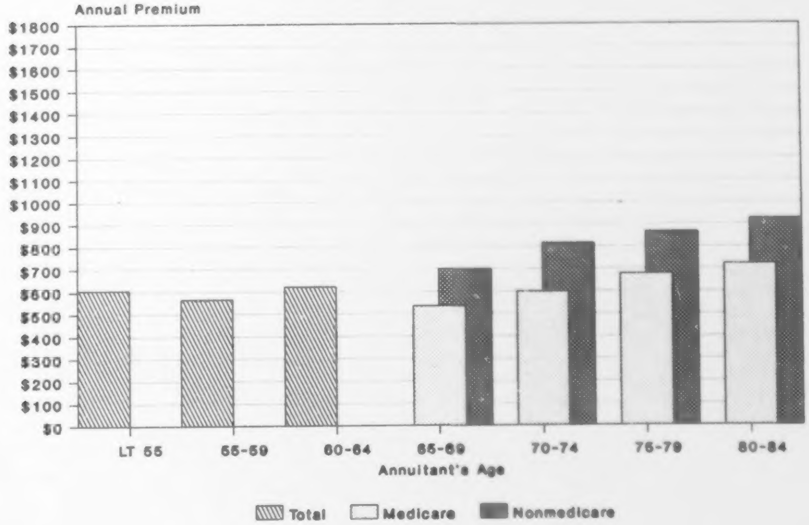
Thus, it would seem that many annuitants have not used the large selection of plans available in FEHBP to lower their share of premium costs. They appeared to be reluctant to switch plans even though from a purely economic perspective it would have benefited them substantially to do so. However, these data actually show the combined effect of Medicare coverage and the fact that the tendency to be in high-priced plans correlates with older age. Separating these two trends shows that Medicare coverage does appear to have some effect in plan choice, as shown in the following graph. Nonetheless, the magnitude of the effect of Medicare coverage is still smaller than economic logic would dictate.

FIGURE 7.1

Mean FEHBP Premium of Annuitants with Family Coverage, by Age and Medicare Coverage--1988



Mean FEHBP Premium of Annuitants with Self Only Coverage, by Age and Medicare Coverage--1988



If examined purely on the basis of the relationship of employee premiums to the "value"--here defined as pure premium value--of the benefits received from the carrier, annuitants with Medicare do quite well. As shown in table 7.3, the ratio of their *average* pure premium values compared to their *average* premium payments ($2,026/$1,079) reflects a gain on their premium of 88 percent. However, as shown in the following tables 7.5 and 7.6, the typical annuitant with Medicare enrolled in BC/BS High Option or AFGE High Option receives less than the "value" of his or her share of the premium. Additional data on pure premium values compared to premium payments, by plan, are shown on tables 7.10 through 7.12 at the end of this chapter.

TABLE 7.5. Relative Pure Premium Value of FEHBP Plans Compared to Premiums Paid by Annuitants with Self Only Coverage and Medicare, 1989

Plan	Pure premium value[a]	Enrollee share of actual premium	Gain on actual premium for Medicare enrollees
BC/BS High	$1,905	$2,197	-13.3%
BC/BS Standard	1,303	393	231.6
Aetna High	2,033	2,024	0.5
Aetna Low	1,614	792	103.7
AFGE High	1,817	2,051	-11.4
AFGE Standard	818	276	196.7
GEHA	1,307	464	182.0
NALC	1,467	739	98.6
Postmasters Hi	1,929	1,392	38.5
Postmasters Low	958	317	202.7
Rural Carriers	1,470	810	81.6
NTEU	966	325	197.6
Foreign Service	1,309	570	129.9
SAMBA	1,277	490	160.5
Mailhandlers Hi	846	285	197.1
Mailhandlers Low	718	275	16[illegible].8
Alliance High	1,531	822	86.1
Alliance Low	771	244	216.1
APWU	1,346	484	177.8
BACE	1,033	513	101.2
Secret Service	1,057	335	215.5
NAGE High	2,296	1,826	25.8
NAGE Low	977	321	204.3
NAPUS	1,356	1,067	27.0
NFFE High	1999	1,438	39.0
NFFE Low	1,314	612	114.8
Postal Superv.	1,510	712	112.0
HMSA	955	324	195.0
GHI	1,131	352	220.8
Kaiser No. Cal.	945	295	219.7
Kaiser So. Cal.	998	316	215.5
Foundation	1,184	434	173.0
GHA High	1,061	362	192.8
GHA Low	742	253	193.2
Kaiser Mid-Atlan.	1,067	304	251.3
HMO Fla.	1,003	342	193.2
Michael Reese	776	265	193.2

[a] Annual "pure premium" cost as discussed earlier.

Source: FEHBP Model.

TABLE 7.6. Relative Pure Premium Value of FEHBP Plans Compared to Premiums Paid by Annuitants with Family Coverage and Medicare, 1989

Plan	Pure premium value[a]	Enrollee share of actual premium	Gain on actual premium for Medicare enrollees
BC/BS High	$3,689	$4,543	-18.8%
BC/BS Standard	2,500	825	202.9
Aetna High	3,972	3,824	3.8
Aetna Low	3,152	1,849	70.5
AFGE High	3,492	3,738	-6.6
AFGE Low	1,676	599	179.6
GEHA	2,505	875	186.1
NALC	2,795	1,238	125.8
Postmasters Hi	3,706	2,966	24.9
Postmasters Low	2,201	772	185.2
Rural Carriers	2,796	1,196	133.9
NTEU	2,056	733	180.4
Foreign Service	2,999	1,670	79.6
SAMBA	2,355	1,670	41.1
Mailhandlers Hi	1,647	736	123.9
Mailhandlers Low	1,383	652	112.0
Alliance High	3,836	2,744	39.8
Alliance Low	1,512	657	130.2
APWU	2,694	941	186.1
BACE	2,299	1,417	62.3
Secret Service	2,491	838	197.3
NAGE High	5,056	4,440	13.9
NAGE Low	2,198	767	186.7
NAPUS	2,724	2,157	26.3
NFFE High	4,310	3,407	26.5
NFFE Standard	2,908	1,624	79.0
Postal Superv.	2,862	1,904	50.3
HMSA	1,867	858	117.6
GHI	2,172	1,312	65.6
Kaiser No. Cal.	1,824	693	163.3
Kaiser So. Cal.	1,964	787	149.6
Foundation	2,043	1,110	84.0
GHA High	2,153	848	154.0
GHA Low	1,427	645	121.1
Kaiser Mid Atlan.	2,112	748	182.3
HMO Fla.	1,854	839	121.1
Michael Reese	1,559	705	121.1

[a] Annual "pure premium" cost as discussed earlier.

Source: FEHBP Model.

Annuitants with Medicare would improve the return on their FEHBP premiums by moving out of plans with a high concentration of annuitants without Medicare and from higher-cost to lower-cost plans. Although the 1989 figures are not yet final, preliminary data from OPM show that in the latest open season BC/BS High Option lost 63,000 annuitants, a 19 percent reduction, while BC/BS Standard Option gained 81,000 annuitants. Almost 60,000 annuitants switched from High to Standard Option within BC/BS.[73]

Such data indicate that annuitants with Medicare may be making more logical choices about their FEHBP coverage. However, while switching may reduce the problem of annuitants' overinsuring themselves, it raises another problem--as lower-cost recipients leave, the cost (and thus the premiums) of BC/BS High Option and the two Aetna options will rise even further, since only the higher-risk groups are likely to be left in the plans. This, in turn, may jeopardize the continuation of these plans as FEHBP options, since premiums could become prohibitively high.

e. Should annuitants be placed in separate risk pools? It can be argued that pure premium cost comparisons for FEHBP annuitants with Medicare do not completely address the issue of whether FEHBP treats them "fairly." The fairness question arises at least in part because it is commonly perceived that the Federal Government will help pay for health insurance on behalf of annuitants and workers alike. No explicit policy or legislative provision exists suggesting that annuitants with Medicare should get a higher or lower Federal share or contribution. If it were accepted that the proportion of the cost borne by the Government should be the same for all segments of the FEHBP population, the Federal contribution paid on behalf of annuitants with Medicare would appear to be too low. From this perspective, it could be argued that the cost experience of the FEHBP plans should be segmented to show the separate impact of FEHBP annuitants with Medicare, annuitants without Medicare, and active workers, so that the Federal share could be made the same proportion for each group.

Data from OPM show that the average enrollee share of the total cost of all FEHBP benefits is 29 percent. This average share represents 18 percent of the costs of benefits for annuitants without Medicare, 38 percent for annuitants with Medicare, and 34 percent for active workers. Put another way, if annuitants with Medicare were treated as a separate risk group, and, holding all else equal, the Government continued to pay for 71 percent of their FEHBP benefits, the premiums they pay could be reduced by about a quarter of their current level. Thus, placing annuitants in separate risk pools under FEHBP could raise the proportion of the Federal contribution for FEHBP annuitants with Medicare (with a commensurate reduction in their premiums), lower it for those without Medicare (with a commensurate increase in their premiums), and raise it slightly for active workers (with a commensurate slight decrease in the employees' premiums).

In the private sector, retirees are sometimes segmented into separate risk pools, especially as the insured group matures and costs attributable to

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[73] *Retirement Life*. May 1989. p. 16. Whether the switching from High to Standard Options was due to an overall increase in understanding by annuitants of their situation, or to the effect of the new Medicare catastrophic coverage, is unclear.

retirees grow. Whether segmented or not, the average rate for all enrollees usually does not vary significantly from the average rate for employees alone, because the large majority of private sector retirees are covered by Medicare. Retirees in FEHBP, on the other hand, on the whole significantly increase the average cost of FEHBP plans because a large proportion (49 percent) are not covered by Medicare.

However, it may be that the high utilization of the annuitants without Medicare has more to do with their age than their status as annuitants. Use of medical care rises with age. Almost one-third of annuitants enrolled in FEHBP are not old enough to be eligible for Medicare, but are relatively high users of medical care because they are among the oldest enrollees. The same phenomenon is true of workers. If FEHBP participants were to be segmented further into risk pools, the basis could be adjusted for "higher age" rather than active worker or annuitant status. In other words, if segmentation according to risk is to be emphasized more in setting FEHBP premiums and Government contribution rates, the full range of groupings should be explored; age and annuitant status are simply two of a number of factors used by health insurers to establish premiums. Finally, adjusting for one or another set of risks in a population covering 9 million people may open the door to a multitude of adjustments leading to widely varying risk groups and premiums and thereby eroding a fundamental insurance element--i.e., the broader the group, the greater the benefits of pooling risks. It would also make FEHBP much more cumbersome to administer.

2. *The Effect of Medicare's New Catastrophic Coverage*

The new Medicare catastrophic benefits largely duplicate coverage provided by FEHBP plans. Accordingly, FEHBP annuitants with Medicare (like other retirees who have medical insurance in addition to Medicare) complain that they are paying more for health insurance but getting nothing new for it.

The impact of the new Medicare premiums is not uniform--not everyone will pay them, and for those who do, the amounts will vary widely. FEHBP enrollees with less than $150 of income tax liabilities and who are not enrolled in Part B of Medicare will pay nothing for the new Medicare protection. In 1989, annuitants who are eligible for Parts A and B of Medicare will receive a $3.10-a-month rebate from OPM--$37.20 for the year--meant to compensate for the duplicative coverage. Those who are enrolled in Part B will have to pay the new $4.00-a-month add-on ($48.00 a year) to the regular Part B premium.

The strongest arguments against paying for duplicate coverage come from those who have income tax liabilities of $150 or more because they will have to pay the supplementary premium (surtax). Even assuming the maximum deduction of the annuity allowed in the law ($6,000),[74] in 1989 a single annuitant eligible for Part A of Medicare could be liable for the supplemental premium if his or her adjusted gross income (AGI) exceeds $12,849.[75] Since the average annual annuity alone of Federal retirees is $15,000, it is likely that a majority of those with Medicare will be required to pay the new surtax. An annuitant with an AGI of $26,000 (again, at least $6,000 of which is an annuity) could be liable for more than $300. The maximum premium of $800 could be required with an AGI of $37,000.

3. *How Well do Federal Annuitants Fare under FEHBP when Compared to Retirees in the Private Sector?*

The issue of how well FEHBP serves Federal annuitants also can be posed in terms of how the program compares to retiree health benefits in the private sector. Basically, the health insurance system for private sector retirees is the same as in the Federal sector; employer-provided plans meet coverage needs before age 65 and then become the secondary payers to Medicare.

The *1988 Hay/Huggins Benefits Report (HHBR)* shows that 77 percent of the 656 employers who responded to questions about retiree health benefits said that they provided some sort of health care coverage to their retirees. Five percent reported that they provided it to early retirees only, 11 percent reported that they provided it to "normal" (i.e., age 65 and over) retirees only, and 61 percent reported that they provided it to both early and normal retirees.

Employers in the private sector have approached the question of retiree health benefits in a variety of ways. Generally, they fit into one of the following modes:

1. The employer provides health insurance, which is coordinated with Medicare:

    a. Medicare "carve out"--the plan has the same coverage for retirees as for active workers, but subtracts what Medicare pays. This means the retiree pays at least the plan's annual deductibles and coinsurance;

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[74] Federal annuitants are permitted to take a reduction in their tax liability for the purpose of computing the amount of the income-related premium. In 1989 the reduction is calculated by taking the lesser of $6,000 ($9,000 for a couple) or the amount of their Federal annuity, subtracting any social security benefit, and multiplying the result by 15 percent. Adjustments also are made if the annuitant claims the tax credit for the elderly. This provision was intended to bring parity between governmental retirees and social security recipients, who can exclude much (at least half) if not most of their social security benefits in figuring AGI.

[75] Assumes single personal exemption, standard deduction and special deduction for the elderly, and no special tax credits.

b. Coordination of benefits--the plan pays the difference between what Medicare pays and the plan's total covered expenses. This means that Medicare and the plan together pay for virtually all the retiree's covered medical expenses (this is how FEHBP and Medicare are coordinated); and

c. Medicare supplement--the plan pays an amount approximately equal to the Medicare deductibles and coinsurance. This means that Medicare and the plan together pay for virtually all of Medicare-covered services.

2. No health insurance is provided, but the employer pays the Part B premium under Medicare for their retirees.

3. No health insurance is provided.

TABLE 7.7. Prevalence of Various Types of Retiree Health Insurance Arrangements in the Private Sector, 1989 (in %)

Employer supplements Medicare	Employer reduces own plan $1 for $1 for Medicare	Employer offers no plan to retirees	Employer only buys Part B
45%	25%	25%	5%

Source: Hay/Huggins Company, Inc.

FEHBP coverage of retirees most closely resembles the coordination of benefits approach, where virtually 100 percent of covered services are paid through the combination of Medicare and the employer plan. Most private employer plans provide at least the same level of coverage (offsetting for Medicare) for retirees as for active employees. In *HHBR*, 81 percent of 461 respondents that cover retirees over age 65 described their plans as such. Approximately 11 percent of 627 respondents said they paid the Medicare Part B premium for their retirees.

Slightly over half of the employer respondents to the Hay/Huggins survey reported paying fully for the cost of coverage for the retirees over age 65. Slightly over one-third said that they paid fully for dependents' coverage. The remainder reported either sharing the cost with retirees or requiring them to pay for it by themselves.

TABLE 7.8. Financing of Private Employer-Based Health Insurance for Retirees, 1988

	Percentage of plans reporting method of financing:	
	Retirees under age 65	Retirees age 65 and older
For retiree:		
Fully paid by employer	51%	52%
Shared by employer/retiree	32	28
Paid by retiree	17	20
For dependents of retiree:		
Fully paid by employer	36	38
Shared by employer/retiree	43	37
Paid by retiree	21	35

Source: *1988 Hay/Huggins Benefits Report.*

The Hay/Huggins survey data do not represent a truly scientific sample. However, they are consistent in various respects with a 1987 survey of employee benefits conducted by the BLS. That survey, covering medium and large firms with a representative population of 21.3 million full-time workers, showed that, in 1986, 76 percent of the workers were in plans where health insurance coverage extended into retirement (see table 7.9). It found that where such coverage was provided, it almost always continued up to age 65, and in 90 percent of the cases, it continued after age 65. Employers provided the coverage at no cost to about half of the retirees (although the study found that there had been a notable decline in no-cost coverage from 1980 to 1986) but required about 15 percent of retirees to pay the full cost. Employers shared the cost with about 30 percent of retirees under age 65 and about 20 percent of those 65 and older.

TABLE 7.9. Extent of Retiree Health Coverage in Medium and Large Firms

Percent with retiree coverage; type of coverage; financing of coverage[a]

Percent of participants in plans:

With retiree coverage	76%
Without retiree coverage	21%

Type of coverage in plans with retiree health benefits:

	Percent of retirees	
	Under age 65 with	Age 65 and older with
Coverage in this age group:	99%	90%
Same coverage as workers	(78)	(71)
Reduced coverage	(18)	(16)
Increased coverage	(1)	(1)
No coverage in this age group:[b]	1	10
Financing of coverage in plans with retiree health benefits:		
Fully paid by employer	51	52
Shared by employer/retiree	30	22
Fully paid by retiree	15	14

[a] Totals may not equal 100 percent because some plans' provisions were not determinable.

[b] Retiree coverage is provided in one of these age groups but not the other.

Source: U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in Medium and Large Firms, 1986.* Bulletin 2281. June 1987.

While the BLS study found that retirees' health benefits were generally the same as workers', 18 percent of retirees under age 65, and 16 percent of retirees age 65 and older, received reduced coverage after retirement. Also, the Wyatt Company reports that one quarter of the firms it surveyed in 1988 said that they had modified their retiree health plans or anticipated doing so during the next year. Six percent had already taken action to reduce or eliminate future retiree medical benefit liabilities.[76]

Thus, from the standpoint of the amount of insurance coverage they receive through their employers, in the aggregate private sector retirees do not appear to fare as well as Federal annuitants. While the majority have comparable coverage--where the employer plans coordinate benefits with Medicare as FEHBP does under a coordination of benefits approach--many also are in carve-out plans or do not receive any coverage through their employers.

This disadvantage is said to be partly offset because, in contrast to the Federal Government, private sector employers often provide their retirees with health insurance at no cost. However, as the previous data indicate, this practice is prevalent but not uniformly applied, and appears to be declining. Moreover, where the employers do pay fully, it is usually only a continuation of their practice for active workers, where no-cost health insurance is seen as a fringe benefit. The health insurance coverage appears to be free since the employees and annuitants do not pay for it directly. In fact, it is probably factored into their overall compensation. In other words, their wages or perhaps their pensions would be higher if their employers did not provide free medical insurance. Thus, the premium that Federal annuitants pay for FEHBP coverage is merely one factor to consider in comparing total compensation of Federal workers and retirees to their private sector counterparts.

4. Are FEHBP Annuitants Affected Differently than Private Sector Retirees by Medicare Catastrophic Health Insurance?

The consequences of Medicare's catastrophic health insurance are basically the same for FEHBP annuitants and private sector retirees. The new taxable-income-related premiums--the major source of complaint--must be paid by Medicare Part A eligible (or "would be" eligible) retirees in both sectors. For the most part, the new protections will simply replace coverage previously available under employers' plans.

In the Federal sector, the law requires that a rebate be given to FEHBP participants with Medicare, based on the amounts the new Medicare benefits are estimated to save the FEHBP plans. (As previously mentioned, in 1989 these expected savings have resulted in a $3.10-a-month rebate.) In the private sector, employers that provide retiree health benefits under plans that duplicate at least 50 percent of the new Medicare catastrophic benefits must provide the retirees with an equivalent amount of additional benefits under their plans or refund the amounts saved because of the Medicare duplication.

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[76] Wyatt Company. *Retiree Medical Plans: Problems on the Horizon*. The Compensation and Benefit File, v. 5, Jan. 1989. p. 10.

One difference between the Federal and private sectors with regard to the new Medicare catastrophic insurance concerns accounting for duplicative coverage. Under the law, there is no expiration to the provision requiring OPM to provide rebates to FEHBP annuitants for the amounts the FEHBP plans save, while for private employers, the so-called "maintenance of effort" requirements (either to add benefits or to refund savings) apply only through 1989 with respect to Medicare Part A overlaps and only through 1990 for Medicare Part B overlaps. Further, these maintenance of effort provisions do not apply to benefits provided under collectively bargained multiemployer plans.

Other differences between private and public sector retirees arise because of the way the new Medicare taxable-income-related premium (the surtax) is computed. Social security benefits are not taxable if the retiree's AGI plus half the benefits are less than $25,000 ($32,000 for a couple), and thus social security benefits count in determining the new Medicare surtax only for higher-income retirees. When AGI plus half the benefits exceed the $25,000 and $32,000 thresholds, no more than half the social security benefits can be taxable (and thereby count in computing the surtax).

Federal annuities, on the other hand, are largely taxable (usually 90 percent or more) without income thresholds, and therefore ordinarily would count in computing the surtax for virtually any Federal annuitant eligible for Part A of Medicare. Because it was perceived to be inequitable to charge Medicare beneficiaries with equal amounts of retirement incomes different supplemental premium amounts merely because of the differing tax treatment of different kinds of retirement income, the new law includes an adjustment for retirees with governmental annuities. In 1989, 15 percent of $6,000 ($9,000 for a couple) of the Federal annuity (or the whole amount of the annuity if smaller) can be deducted from tax liability in the computation of the surtax. The $6,000 and $9,000 figures were explicitly set as a surrogate for the portion of the Federal annuity that is analogous to social security benefits (and therefore would be partially or fully exempt from taxation--see footnote 7).

Using a rough measure of what portion of a Federal annuity might be viewed as a "substitute" for social security--40 percent for a worker with a "typical" Federal career--it would appear that the $6,000 exclusion ranges from being adequate to being too generous for Federal retirees with annuities under $15,000 or so in 1989. However, for those with annuities in the low $20,000 range and modest amounts of additional taxable income ($5,000-$10,000), the $6,000 exclusion may be too small and thus the surtax may be said to be too large. At higher income levels, the situation reverses itself again slightly, but overall the $6,000 exclusion appears to be adequate. Thus, because the exclusion rules are broad proxies for the influence of social security on the surtax computation, the actual effect of the supplemental premiums on Federal retirees can be different from that of retirees with similar income levels in the private sector.

In the aggregate, the effect on Federal and nonfederal retirees of the introduction of the new catastrophic benefits under Medicare does not appear to be significantly different. However, to the extent that private employers do not continue the so-called "maintenance of effort" practices beyond the period required in the law (i.e., after 1990), Federal retirees would be in a slightly advantageous position since there is no expiration in the comparable "rebate" requirement for FEHBP plans.

5. Should the Federal Government Purchase Medicare for Annuitants not Otherwise Eligible?

Purchasing Medicare coverage for all annuitants obviously would lower FEHBP costs, as Medicare would be the primary payer of benefits for more FEHBP participants. These annuitants would receive a higher degree of coverage, as their FEHBP deductibles and coinsurance would be waived. To the extent all annuitants over age 65 would have uniform coverage under Medicare, administration would be simplified and the issue of subsidization ameliorated.

However, cost savings would be limited because most nonmedicare-covered annuitants are too young to be enrolled in Medicare. Moreover, Medicare costs would rise in turn, and the costs to the Government of the buy-in would have to be financed. (The 1989 premiums for buying into Medicare are $156 a month for Part A and $31.90 for Part B.) Therefore, it is not clear what would happen to net Federal costs--it might be a "wash." If one accepts that Medicare's cost containment efforts are more effective than those of private carriers, such a proposal might produce some savings. However, it is debatable whether, over an extended period, the aggregate impact of private and public efforts to contain costs would be noticeably different.

There is also the question of what, if any, financial contribution the annuitant should make under such an approach--would he or she continue to elect a FEHBP plan and pay the usual premium? Would the Government contribute to this plan as well as buy the individual into Medicare? Would the individual have to pay any part of the Medicare premiums? Without constructing a specific plan, it is difficult to draw any "intuitive" conclusion. Medicare's new catastrophic coverage also clouds the picture. Annuitants who buy into Part A of Medicare are not required to pay the supplemental premium. A situation could be created where the Government bought the annuitant into Part A, or Parts A and B, and the annuitant would pay neither the "buy-in" premiums nor the income-related premium. In effect, these annuitants would get Medicare for free, in contrast to their peers who may have paid a substantial amount of HI taxes over their careers and also must pay the supplemental and the Part B premiums as retirees.

Finally, if the current formula for determining the Government contribution were to remain unaltered, then the effect of changing this group (annuitants over age 64 without Medicare) from the highest- to the lowest-cost category might be to lower the amount of the Government contribution. Also, the efficacy of this proposal is limited by time, because eventually virtually all Federal annuitants will have earned eligibility for Medicare through their Federal employment.

6. *Should the Government Provide "Medigap" Policies for Annuitants?*

The issue of duplicate coverage for annuitants with Medicare has led to proposals that would provide benefits only as a supplement to Medicare, instead of the more comprehensive coverage now offered under FEHBP. The foremost example of interest in this issue is the provision in the Medicare catastrophic legislation (section 423 of P.L. 100-360) that requires OPM to submit a report to Congress regarding changes to FEHBP that may be necessary to incorporate plans designed specifically for annuitants with Medicare.[77]

One issue in designing a medigap plan is whether participation would be voluntary or compulsory. If voluntary, then dually eligible individuals could choose to remain in their FEHBP plan, perhaps because it might provide more generous coverage, or because the annuitant has a spouse under age 65 who needs coverage that the medigap plan would not provide. However, a voluntary approach might cause instability in FEHBP due to continuous enrollments and disenrollments. Mandatory participation in medigap plans would avoid this problem and simplify administration, but such action might be viewed as too arbitrary and be strongly resisted.

Clearly a medigap plan would apply to annuitants with both Part A and Part B of Medicare. Less clear, however, is whether annuitants with just Part A, or just Part B, would be covered.

Another issue in designing a medigap program would be to determine if Medicare coverage would be extended to *all* annuitants who are over age 64 or disabled. If so, would participation in Medicare be compulsory? Presumably this would present no problem to enrollees if the Government bore the cost of purchasing Medicare coverage for those age 65 and over but not otherwise eligible for Medicare's benefits. If the Government did not purchase Medicare for these annuitants, probably few would voluntarily choose to pay the $156 a month (in 1989) for Part A coverage, in addition to their medigap premium, in lieu of FEHBP.

If the Government did purchase Medicare for these annuitants, should it purchase just Part A, Part A and Part B, or Part B for those eligible for Part A? If the Government purchased Part B, should it also pay the late enrollment penalty for those who did not choose Part B at their first opportunity? (The Part B premium is increased by 10 percent a year after first eligibility--this penalty could make Part B more expensive than a FEHBP plan for many enrollees.)

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[77] The report was issued in May of 1989, too late to be included in this analysis.

There is also the question of how extensive the coverage of any medigap policy would be. If it were limited to the NAIC[78] guidelines, it probably would provide less coverage than currently available under FEHBP. One possible structure for the supplemental policies would be like the Medicare supplemental policies some private sector employers provide, which cover Medicare deductibles and coinsurance. Additional benefits such as dental and vision care could be offered as separate options.

If the medigap policies were financed separately from FEHBP, FEHBP's total expenditures would go down. However, FEHBP costs attributable to the remaining FEHBP enrollees would go up due to the loss of the "subsidy" (i.e., lower FEHBP costs) associated with annuitants with Medicare. If the Government also bore the cost of the medigap plans, this could make the total cost to the Government greater than FEHBP under current law. If the Government purchased Medicare for all annuitants age 65 and over, both FEHBP and enrollee costs would go down because Medicare would be picking up more of the cost, but the total cost to the Government would climb.

On the whole, a medigap option appears to be advantageous for aged annuitants, especially if the Government provides "free" additional Medicare coverage. Although their total coverage might decrease if they chose not to purchase additional benefits in their medigap plan, they would not be required to pay any FEHBP premiums at all. Other FEHBP enrollees would see the costs of their premiums increase if the Government did not purchase Medicare, but if it did, their premiums would decline because of the large shift in costs to Medicare.

An attractive feature of Medicare supplemental plans is that they could eliminate the confusion and misunderstanding now prevalent when annuitants choose health plans. As discussed earlier, annuitants, especially those with Medicare, often do not seem to exercise rational choice in selecting health plans. If a medigap option offered or arbitrarily placed annuitants in a plan that is coordinated with Medicare, there would be less opportunity for the annuitant to choose duplicative coverage. Because annuitants with Medicare would be separate from other enrollee groups, questions of "subsidization" and "moneysworth" would also be ameliorated. Finally, by not being in plans designed to accommodate younger age groups, annuitants might receive a benefit package designed specifically to meet the health needs of elderly enrollees. Removing Medicare-eligible annuitants from the insurance pool, however, might exacerbate risk selection in the remaining group.

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[78] The National Association of Insurance Commissioners (NAIC) is a voluntary organization composed of State insurance Commissioners. It has developed models of statutes and regulations for States to adopt for regulating medigap policies. The September 1988 NAIC models, developed after the enactment of the Medicare Catastrophic Coverage Act, include coverage of either all or none of Medicare's inpatient hospital deductible, coinsurance for skilled nursing facility services, coverage of blood deductibles, coverage of Part B coinsurance up to the catastrophic limit, and coverage of the coinsurance for covered home intravenous and immunosuppressive drugs.

TABLE 7.10. Pure Premium[a] Values, Enrollee Premiums, and Population, by FEHBP Plans, 1989

	Self only			Family		
Plan	Pure premium value	Enrollee premium	Enrollees[b]	Pure premium value	Enrollee premium	Enrollees[b]
BC/BS H	$3,045	$2,197	160,818	$6,428	$4,543	102,235
BC/BS L	1,364	393	480,450	2,866	825	724,304
Aetna H	2,934	2,024	32,088	5,868	3,824	24,959
Aetna L	1,768	792	66,275	3,973	1,849	59,567
AFGE H	2,896	2,051	5,129	5,667	3,738	8,064
AFGE L	950	276	5,031	2,065	599	9,712
GEHA	1,514	464	77,490	3,186	875	256,228
NALC	1,777	739	54,934	3,539	1,238	172,663
Postmas. H	2,288	1,392	6,133	4,936	2,966	9,574
Postmas. L	1,112	317	5,772	2,712	772	9,618
Rur. Carr.	1,770	810	10,258	3,363	1,196	32,670
For. Serv.	1,520	570	3,424	3,695	1,670	4,695
NTEU	1,122	325	3,964	2,533	733	6,872
SAMBA	1,528	490	8,522	3,891	1,670	14,175
Mailhan. H	1,000	285	121,624	2,585	736	345,769
Mailhan. L	986	275	8,897	2,336	652	20,685
Alliance H	1,777	822	4,892	4,726	2,744	2,212
Alliance L	844	244	12,485	2,272	657	13,980
APWU	1,479	484	46,026	3,131	941	78,627
BACE	1,199	513	1,123	2,832	1,417	738
Secret S.	1,227	335	597	3,069	838	1,587
NAGE H	2,666	1,826	2,814	6,228	4,440	3,717
NAGE L	1,135	321	4,019	2,707	767	7,638
NAPUS	1,993	1,067	1,605	4,203	2,157	6,867
NFFE H	2,320	1,438	1,639	5,309	3,407	1,659
NFFE S	1,525	612	5,091	3,582	1,624	9,690
Postal S.	1,665	712	10,324	3,947	1,904	27,726
HMSA	1,180	324	9,129	3,126	858	15,201
GHI	1,231	352	30,181	3,403	1,312	29,085
Kaiser N.	1,082	295	36,623	2,538	693	56,852
Kaiser S.	1,158	316	27,381	2,882	787	41,329
Foundation	1,479	434	1,912	3,385	1,110	2,966
GHA H	1,328	362	11,875	3,105	848	9,931
GHA L	928	253	3,887	2,364	645	4,447
Kaiser MA	1,113	304	11,496	2,741	748	15,413
HMO Fl.	1,254	342	1,155	3,071	839	2,000
M. Reese	970	265	2,753	2,583	705	3,713
All[c]	$1,563	$807	1,504,903	$3,194	$1,352	2,508,270

[a] As described earlier in footnote 3.

[b] Active workers and annuitants.

[c] All plans in CRS study--some small plans are not portrayed here to save space.

Source: FEHBP Model.

TABLE 7.11. FEHBP Plan Pure Premium[a] Values for Enrollees with Self Only Coverage, 1989

Plan	All enrollees	Nonmedicare enrollees	Medicare enrollees
BC/BS High	$3,045	$3,777	$1,905
BS/BC Low	1,364	1,401	1,303
Aetna High	2,934	3,733	2,033
Aetna Low	1,768	1,973	1,614
AFGE High	2,896	3,466	1,817
AFGE Standard	950	971	818
GEHA	1,514	1,544	1,307
NALC	1,777	1,898	1,467
Postmasters Hi	2,288	2,358	1,929
Postmasters Low	1,112	1,200	958
Rural Carriers	1,770	2,044	1,470
NTEU	1,122	1,131	966
Foreign Service	1,520	1,621	1,309
SAMBA	1,528	1,553	1,277
Mailhandlers Hi	1,000	1,008	846
Mailhandlers Low	986	1,018	718
Alliance Hi	1,777	1,819	1,531
Alliance Low	844	863	771
APWU	1,479	1,566	1,346
BACE	1,199	1,200	1,033
Secret Service	1,227	1,241	1,057
NAGE High	2,666	2,693	2,296
NAGE Low	1,135	1,192	977
NAPUS	1,993	2,160	1,356
NFFE High	2,320	2,339	1,999
NFFE Low	1,525	1,539	1,314
Postal Supervisors	1,665	1,672	1,510
HMSA	1,180	1,234	955
GHI	1,231	1,241	1,131
Kaiser No. Cal.	1,082	1,121	945
Kaiser So. Cal.	1,158	1,195	998
Foundation	1,479	1,516	1,184
GHA High	1,328	1,361	1,061
GHA Low	928	967	742
Kaiser Mid-Atlan.	1,113	1,114	1,067
HMO Fla.	1,254	1,260	1,003
Michael Reese	970	983	776
All[b]	$1,563	$1,612	$1,429

[a] As described earlier in footnote 3.

[b] All plans in CRS study--some small plans are not portrayed here to save space.

Source: FEHBP Model.

TABLE 7.12. FEHBP Plan Pure Premium[a] Values for Enrollees with Family Coverage, 1989

Plan	All enrollees	Nonmedicare enrollees	Medicare enrollees
BC/BS High	$6,428	$7,782	$3,689
BC/BS Low	2,866	2,990	2,500
Aetna High	5,868	6,893	3,972
Aetna Low	3,973	4,603	3,152
AFGE High	5,667	6,291	3,492
AFGE Low	2,065	2,117	1,676
GEHA	3,186	3,251	2,505
NALC	3,539	3,677	2,795
Postmasters Hi	4,936	5,041	3,706
Postmasters Low	2,712	2,888	2,201
Rural Carriers	3,363	3,598	2,796
NTEU	2,533	2,567	2,056
Foreign Service	3,695	3,947	2,999
SAMBA	3,891	4,093	2,355
Mailhandlers Hi	2,585	2,615	1,647
Mailhandlers Low	2,336	2,440	1,383
Alliance Hi	4,726	4,878	3,836
Alliance Low	2,272	2,549	1,512
APWU	3,131	3,268	2,694
BACE	2,832	2,838	2,299
Secret Service	3,069	3,101	2,491
NAGE High	6,228	6,343	5,056
NAGE Low	2,707	2,896	2,198
NAPUS	4,203	4,414	2,724
NFFE High	5,309	5,369	4,310
NFFE Standard	3,582	3,619	2,908
Postal Superv.	3,947	3,996	2,862
HMSA	3,126	3,375	1,867
GHI	3,403	3,512	2,172
Kaiser No. Cal.	2,538	2,650	1,824
Kaiser So. Cal.	2,882	3,005	1,964
Foundation	3,385	3,483	2,043
GHA High	3,105	3,164	2,153
GHA Low	2,364	2,480	1,427
Kaiser Mid-Atlan.	2,741	2,751	2,112
HMO Fla.	3,071	3,099	1,854
Michael Reese	2,583	2,608	1,559
All[b]	$3,194	$3,302	$2,623

[a] As described earlier in footnote 3.

[b] All plans in CRS study--some small plans are not portrayed here to save space.

Source: FEHBP Model.

CHAPTER 8. ADMINISTERING HEALTH INSURANCE PROGRAMS

- Despite a profound evolution of the environment in which the program operates, OPM has not ventured much beyond the limited role envisioned 30 years ago for administering FEHBP.

- Not keeping abreast of private sector innovations in program administration as well as insufficient spending and staff have, according to some observers, precluded OPM from effectively monitoring and managing FEHBP.

- More effective administration might be achieved by adopting methods now widely used in the private sector as well as innovative approaches that are available only to a very large nationwide program such as FEHBP.

- Creating a new independent agency to administer FEHBP is an issue for consideration.

A. Introduction

The task of administering a program as vast in scope as FEHBP is formidable. Since its inception 30 years ago, the program has grown and changed in significant ways. It has done so mostly in response to a profound evolution in the Nation's health care system--an evolution that FEHBP's designers could not have foreseen. That FEHBP has continued to "work" over the years, despite major changes in the environment in which it has operated, reflects the soundness of its basic design.

Nevertheless, serious problems now exist in FEHBP, including ones associated with the administration of the program. Given the interdependency of program structure and administration, in what ways may the latter have contributed to FEHBP's current difficulties? Is there sufficient built-in flexibility in the way that FEHBP is administered to make changes that may be needed? Or has the program, as currently constituted, outlived its usefulness? And, if it has, how might FEHBP be administered if the program were to be substantially restructured? What are the key administrative issues that need to be addressed?

This chapter focuses on the role Congress assigned OPM in administering FEHBP, how the agency has performed its mission, and changes that might be considered. To provide a framework for this analysis, the first section discusses the functions that are generic to administering health insurance programs, whether in the public or private sector. Next, the range of alternatives available to the Federal Government in administering a health insurance program for its employees is explored. Then, against this backdrop, the role and performance of OPM in administering FEHBP are examined. Finally, the chapter addresses six major FEHBP administrative issues.

B. Program Administration: Framework for Analysis

Fundamental to the operation of any health insurance program, whether in the public or private sector, is the performance of a wide range of administrative functions or activities. Many of them are compulsory, "paperwork" type operations such as processing enrollment forms. Others are also obligatory but require considerable knowledge and skill (benefit design, for example.)

In addition to a host of basic administrative functions that must necessarily be performed in administering a health insurance program, there are also ones in the areas of monitoring and managing the program--functions which are not essential *per se* for a program to work, but usually become essential for it to work well. They overlap with, and are an outgrowth of, many of the basic functions. Processing claims forms, for example, is a basic administrative function. But in addition to processing claims, the information they contain can be useful in monitoring and evaluating the program. In turn, insights from monitoring can be used to manage the program more effectively.

To a significant extent, the choice of program structure will dictate which entities--employers, carriers, or outside service organizations--can best perform which functions. On the other hand, for some functions the locus of responsibility is often not critical. What does seem to be critical is a commitment to ensure that--one way or another--the functions are being diligently executed.

Basic administrative functions. Among the basic administrative functions vital to the functioning of an employee health insurance program are the following:

- specify/negotiate benefit design, rates, cost controls
- certify and/or select carriers
- prepare (or approve) and communicate plan(s) to employees
- operate or oversee open seasons
- handle enrollment procedures
- collect employee contributions on a payroll-deduction basis
- pay costs (if self insured) or pay premiums to insurer(s)
- keep certain types of records
- process claims
- adjudicate claims appeals
- assure financial soundness
- audit plans
- invest assets of plan(s)

Monitoring performance. Monitoring the performance of a program refers to those tasks involving data collection, the identification of trends and problems, and the development of reports to assist management in improving efficiency. Monitoring provides the foundation for efforts to improve services, control costs and change enrollee behavior which, in turn, can change the practice patterns of providers.

No monitoring effort can be successful without the development of data bases that provide understanding about how to gain some degree of control over costs. The collection of good data is critical, for example, in reviewing utilization patterns.

By monitoring utilization patterns, a company may determine that its employees are making excessive use of emergency rooms. Analysis may determine that employees are, in effect, using emergency rooms as they might use personal physicians because they have not established a patient/physician relationship. (See appendix G, *Administration: Monitoring Health Insurance Programs*, for elaboration on this subject, including a sample of some of the kinds of benefit data that could be collected and analyzed.)

Managing an insurance program. In this context, managing means formulating and executing strategies based on the information developed by the program's monitoring activities as well as from other sources in order to achieve program goals. Continuing with the previously cited example, for instance, it might be determined that the problem of excessive emergency room use by enrollees could best be addressed by some type of "carrot and stick" approach. As an inducement to seek nonemergency treatment at a physician's office instead of at a hospital, plan reimbursement could be changed to encourage such behavior, and a $50 deductible might be imposed for nonqualifying emergency room treatment.

Successful monitoring and managing require, of course, a knowledgeable staff and an adequate budget. It also essential that those responsible for administering the insurance program have sufficient authority and a clearly articulated mandate to make it work. In the private sector, many businesses have recently reorganized their health care departments, centralized functions, and raised the managers of these departments to higher organizational levels.

As discussed in chapter 5, one of the key developments in health care over the last couple of years is that employers (especially the larger ones) are exerting significant influence as buyers in the marketplace. Similarly, it is anticipated that employers will continue to become increasingly assertive in their development of cost-containment initiatives. In the not too distant past, very few firms in the private sector did much more than complain about the increasing costs of providing their employees with health insurance. Today, many are vigorously attempting to influence those costs.

1. Changing Roles and Responsibilities in Program Administration

Traditionally, employers simply purchased health insurance for their workers from an insurance company, often one the employer dealt with for other types of business insurance, e.g., fire, liability, workmens' compensation. The insurer generally handled all the administrative functions, except for the collection of premiums, and assumed all the risks.

Over the past dozen years or so, most large companies have fundamentally changed the way they administer their health insurance programs. Concerned with skyrocketing health care costs, more and more firms have abandoned their historically passive approach and are now actively monitoring and managing their programs.

Unwilling to continue viewing their role as merely one of executing routine administrative functions, companies are increasingly engaged in implementing cost-containment measures such as managed care, financial incentives designed to encourage enrollees to use less expensive medical care, and health promotion programs.

In the area of managed care, for example, program administration--whether by the employer, an insurance company, an outside service organization, or some combination--frequently includes a number of oversight or watchdog activities to ensure that medical services are being appropriately used as well as billed. These activities often include utilization review, hospital bill audits, and retrieval and analysis of hospital diagnostic, treatment, and billing data. For a discussion of these cost-containment activities, see chapter 4.)

As sharply rising costs have compelled companies to reassess their roles in providing health insurance protection to employees, several innovations in types of insuring mechanisms have been developed, involving different administrative requirements.

Self funding or **self insurance** is one approach that is growing in popularity. A self-insured plan is one in which the company assumes the risks of paying benefit claims. In essence, the employer is acting as an insurance company--paying claims with money traditionally earmarked for premiums. Regardless of the specific self-funding technique a firm chooses, in order to administer such a plan, it will need either to develop in-house capabilities or contract with an outside organization such as a third-party administrator.

Third-party administrators (TPAs) offer another example of the changes taking place. Typically, these are out-of-house, for-profit companies that handle many of the day-to-day administrative functions, although some engage in more complex matters such as benefit design. TPAs often collect premiums, pay claims, and/or provide assorted administrative services for employee health programs.

Still another change in the area of administration is the growing trend of **self administration,** where companies often handle all the administrative functions themselves, without recourse to a TPA or similar service organization. With this approach, some benefits may be insured or subcontracted, while others are self funded. Once the province of only the largest firms--those possessing big personnel and human resource departments--computer innovations have now made it possible for medium-sized companies to establish full-scale claims review and payment procedures.

On the whole, the various administrative efforts of private sector firms appear to be having a desirable effect in the health care marketplace: giving providers and users of health care services incentives to be more conscious of costs.[79]

2. *Wide Range of Government Involvement in Administering FEHBP is Possible*

Given the changing circumstances and practices of private employers just described, what alternatives are available to the Federal Government in the administration of a health insurance program for its employees? If the Government sought to limit its administrative involvement to a bare minimum, letting other program participants perform the vast bulk of administrative functions, what would be its administrative role? Or, at the other extreme, what would be involved if the Government tried to exert the maximum direct administrative control feasible? To better understand the range of possible administrative involvement, the following hypothetical alternatives are presented.

a. Government as "passive" administrator. At one extreme, the Federal Government could limit its involvement in administering FEHBP to the bare essentials necessary to protect the enrollees' rights, guard against fraud, and ensure carrier and program fiscal integrity. This approach would require the least staff and expertise. The administrating agency's role with respect to any plan participating in the program, for example, might be limited to establishing minimum standards for recognition of the plans, permitting all qualified to enter.

Or, as an essentially "passive" administrator, the Government might conduct competitive bidding for insurance carriers and other private sector firms needed for claims processing, utilization reviews, and auditing of claims and providers. Its few responsibilities might include functions such as adjudicating claims disputes, approving carrier communications to enrollees on plan information, and general oversight to protect against fraud.[80]

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[79] Sullivan, Sean. *Managing Health Care Costs: Private Sector Initiatives.* Washington, American Enterprise Institute for Public Policy Research, 1984. p. 1.

b. Government as "active" self administrator. At this level of involvement, most or all administrative support functions involving interactions between enrollees and providers would be handled or closely monitored by the Government. More specifically, the Government's administrative responsibilities might include the following:

- Handle claims administration--responsibility for day-to-day payment of provider services on behalf of participants. Specifically, functions could include:
  - Data processing
  - Claims adjusting
  - Collections and delinquencies
  - Determination of eligibility
  - Claims communications
  - Appeals adjudication
- Design and implement (or contract out) cost-management initiatives to maximize cost efficiencies, including:
  - Preadmissions certification
  - Prospective reviews of proposed medical care
  - Concurrent reviews of inpatient hospital care
  - Second surgical opinions
- Conduct audits, including:
  - Claims auditing to ensure appropriate payments by processors
  - Auditing provider bills to ensure properness
  - Financial auditing
- Establish evaluation procedures to maximize ongoing efficiency initiatives in the following areas:
  - Benefit design
  - Projections of future program costs
- Develop communications techniques to ensure that employees effectively and efficiently utilize the program

c. Government as direct provider of services. At the other extreme, the Federal Government could play an all-encompassing role by both serving as an insurer and providing health care services directly. Under such an alternative, a new Federal agency or department would undoubtedly be needed. Existing models are the military health care system and the Veterans Administration. In addition to those functions and activities listed under the second alternative, the Government's responsibilities could also include:

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[80] It should be recognized that a limited Government role would not rule out self insurance, which is a funding mechanism as opposed to an administrative process.

- Procurement of the personnel and facilities listed below and/or determination of payment schemes for the services they provide:
  - Hospitals and staff
  - Physicians and nonphysician providers
  - Laboratories
  - Pharmacies
  - Dentists
  - Ambulatory care centers
  - Rehabilitation centers
  - Home health care agencies
  - Hospices
  - Other
- Management of all aspects of the Government's health care delivery system
- All communications with employees and annuitants

C. OPM's Role and Performance in FEHBP

Within the framework discussed above, where does OPM stand? What role did Congress envision for FEHBP's administrating agency? Has that mandate been observed? How well has OPM performed its assigned or chosen functions and activities?

1. *Legislative Mandate: OPM's Role*

The FEHB Act of 1959, and its subsequent amendments, establish the parameters for program operation regarding eligibility for benefits and election of coverage by participants; the types of health benefit plans that may be offered; the types of benefits provided; the level of Government contributions; the establishment of an employees health benefits fund to pay for program expenses; the creation of an advisory committee; provisions for studies, reports, and audits; and the role of OPM[81] with regard to contract authority and program administration.[82]

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[81] The Office of Personnel Management (OPM) was known as the Civil Service Commission until 1978. Except for the name change, FEHBP has been continuously administered since its inception by the same entity.

[82] See appendix C for a detailed summary of FEHBP's legislative history.

More specifically, as concerns OPM's role vis-a-vis contracting and program administration, the FEHB Act (Title 5, U.S. Code, Chapter 89) gives the agency the authority to:

- Contract with qualified insurance carriers, comprehensive medical plans (HMOs) and employee organization plans in accordance with regulations developed by OPM. These regulations empower OPM to negotiate benefit levels, premium rates and other financing issues, and to approve or disapprove participation in FEHBP;

- Prescribe reasonable minimum standards for health benefits plans;

- Prescribe regulations for FEHBP participation, change in enrollment and termination of participation by Federal employees, annuitants and dependents;

- Prescribe regulations on open season;

- Set nonpostal employee, annuitant and family contribution rates for each plan within FEHBP, reflecting the maximum Federal Government authorized contribution;

- Make available to each enrollee "such information . . . as may be necessary to enable the individual to exercise an informed choice among the types of plans";

- Administer the Employees Health Benefits Fund, which contains the contributions of enrollees and the Government. The Fund is available for all payments to the plans. Portions of the contributions are set aside in the Fund to pay OPM's administrative expenses ("not to exceed 1 percent of all contributions") and for contingency reserve; and

- Study, on a continuing basis, the operation, administration and experience of the FEHBP plans. To assist OPM, each carrier is required to "furnish such reasonable reports as [OPM] determines to be necessary to enable it to carry out" its responsibilities.

This legislative language makes it appear that OPM was given broad powers with which to administer FEHBP. It would seem that the agency may have had wide latitude to institute changes it felt were needed, particularly in the areas of disseminating information to enrollees and in monitoring and managing the program. However, it is critical to comprehending OPM's role in administering FEHBP during the past 3 decades that its mandate be viewed in the context of the times, then as well as now. Of particular importance is a basic understanding of the prevailing managerial views on administering health insurance programs at the time the program was designed.

When the 86th Congress enacted the Federal Employees Health Benefits Act of 1959 (P.L. 86-382), health care costs were relatively low and stable. Even among the Nation's larger employers, no one associated with insurance was anticipating the necessity for the kinds of innovative cost-containment measures that are becoming commonplace. Those responsible for running corporate health insurance programs were far less sophisticated in purchasing and evaluating health care services than their counterparts of recent years.

Thus, when the FEHB Act was drafted, an active role for the program's administrating agency was not envisioned. So, while some of OPM's powers for administering FEHBP seem ambiguous, but appear open to broad interpretation, it is unlikely that they would have been interpreted broadly by OPM for much of the program's history. It is less clear why OPM has not mirrored the significant changes in administering health insurance programs exhibited by major private employers during the last decade or so. Inertia, administrative frugality, and deregulation under the Carter and Reagan Administrations may be partial explanations.

2. *Evaluation of OPM's Performance*

OPM has managed a huge and complex program over the years, and it has done so with a small staff and budget. And, while some have said that whatever administrative efficiency the program has demonstrated is due to the competitive structure of the program, it seems likely that OPM deserves some share of the credit. Nevertheless, as FEHBP has come under increasingly sharp scrutiny, and as doubts about its long-term prognosis have grown, concerns and criticisms about the administration of FEHBP have intensified.

Many of the concerns and criticisms being expressed are, of course, not new. Some, for instance, surfaced in 1982 at hearings on FEHBP held by the House Subcommittee on Compensation and Employee Benefits. Those hearings revolved around a report on FEHBP (the so-called *Mercer Report*) prepared by William M. Mercer, Inc., an employee benefits consulting firm.[83]

Relevant to the structure and administration of FEHBP, the *Mercer Report* concluded that:

- The proliferation of plan options compromises the Federal Government's capacity to monitor these plans to ensure adequate quality of service and financial solvency;

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[83] U.S. Congress. House. Committee on Post Office and Civil Service. *Review of the Federal Employees Health Benefits Program*. Committee Print, 97th Cong., 2d Sess. Washington, U.S. Govt. Print. Off., 1982. (Hereafter cited as the *Mercer Report*.)

- Competition should be based upon cost, administrative efficiency, quality of service, nature of health care delivery, and controlled benefit level variations, as opposed to being based on the interrelationship between confusing differences in benefit plan provisions and premium rates;

- OPM should ensure that plans do not contain provisions that evidence indicates will lead to adverse selection;

- To ensure quality of service for employees, OPM should establish and enforce minimum uniform standards in such administrative areas as claims turnaround time and accuracy of claims payment;

- OPM should identify specific areas of cost control that all non-HMO plans in FEHBP must implement in a consistent manner;

- OPM should take a more proactive stance in ensuring that FEHBP participants have sufficient information available to make an informed choice.

Last year (1988), however, a number of new concerns and criticisms were voiced in connection with the program and its administration. In addition to those contained in a report by the consulting firm of Towers, Perrin, Forster & Crosby (the so-called *TPF&C Report*),[84] newspaper and journal articles, and other sources, harsh criticisms were leveled at hearings before the subcommittee on May 11 and 18, 1988. Major concerns expressed included:

- In general, OPM has done little monitoring of FEHBP and it has failed to exercise its authority to initiate or require substantive changes. Rather, the agency has been content to simply deal with the margins in important areas such as benefit design and cost control measures;

- Until fairly recently, OPM has made virtually no serious efforts to control the administrative costs of the carriers;

- OPM has not aggressively attacked problems of fraud in FEHBP. Further, under FEHBP carriers are discouraged from doing so because the costs of uncovering fraud are simply viewed as just another administrative cost.

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[84] U.S. Office of Personnel Management. *Study of the Federal Employees Health Benefits Program.* Submitted by Towers, Perrin, Forster & Crosby, Inc. Washington, Apr. 22, 1988. 247 p. (Hereafter cited as *TPF&C Report.*)

D. Major FEHBP Administrative Issues

In examining concerns about FEHBP, some have expressed the view that OPM's limited role is proper and that the bulk of the program's problems lie elsewhere. Others suggest that many of FEHBP's main faults stem from a basic program design deficiency: not vesting OPM with sufficient authority to ensure that competitive forces work at all levels.

A basic principle of the economic theory undergirding capitalist economies is that free and open competition will produce the greatest good for the most people. In a purely competitive environment, the "unseen hand of the marketplace" will guide the establishment of a price for a good that will bring into balance the production of suppliers and the demand for the good from consumers. Arriving at this competitively established price is central to an efficient market from an economic point of view.

Since FEHBP in many ways appears to resemble such a competitive market, given the large number of suppliers of health insurance, the choices available, and the several million consumers demanding coverage each year, consideration of FEHBP reform should address the question of whether particular approaches to reform would interfere with a competitive marketplace and what the effects might be. That consideration should begin with the question of how much competition there really is within FEHBP.

For a variety of reasons, real-world markets are--to varying degrees--nearly all imperfect. That is, competition is usually limited in ways that materially affect the workings of the market. Such limitations are readily apparent in the operation of FEHBP. These limitations include the following:

- *Restrictions on entry of carriers.* In an ideal market, suppliers can enter without restriction. In FEHBP, conventional plans are approved only through legislation. HMOs can enter more easily by meeting OPM's regulatory standards. The easier entry by HMOs may facilitate their positioning themselves to take younger enrollees away from the conventional plans.

- *Product differentiation.* Although many FEHBP carriers offer similar plans, no two plans are exactly alike. The differences, which often provide choices of more of one of benefit versus less of another, make price shopping by consumers more difficult.

- *Imperfect information.* The information available to consumers is not sufficient to evaluate with much precision the worth of each offering. Thus, choices are, at best, based on incomplete information, and, at worst, may be described as ill-informed. To the extent that some consumers understand the system and can predict their own need for health care services, these consumers will gain an advantage over others in obtaining value for their money.

- *Nature of the product.* Under FEHBP, the consumer is not simply buying health care coverage for 1 year. Instead, the consumer is buying into a distinct pool of enrollees of a given plan. The characteristics of both the plan and the pool's enrollees will determine the price and, hence, the worth of the purchase to the consumer. Most consumers do not recognize that pooling helps determine price, nor could they evaluate it if they did understand this point, although they do know the price (premium) at the time of purchase.

- *Attenuation of market forces by Government subsidies.* The Government's subsidy of each plan's cost lessens the impact of price differences on consumer behavior. For suppliers, their latitude to recoup losses through the next year's premium charges lessens their incentive to control costs.

Given these limitations on competition within FEHBP, it seems likely that the full advantages of open competition are not being realized. The most important manifestations of these limitations are: (1) a range of choices that, while significant, falls short of the ranges available in the centrally designed programs of many other large employers; (2) product pricing that is perhaps more sensitive to the health status of a plan's enrollees than to the basic value of the plan's offering; (3) a set of outcomes that favors the most knowledgeable enrollees; and (4) confusion for consumers who want to price-shop but have difficulty in determining the real value differences among the plans.

It has been argued that, in fact, health insurance markets, if left to a pure market determination, will produce outcomes that are neither efficient nor fair, that no modern insurance market is unregulated, and that the free-market approach that FEHBP adopts provides a reasonable amalgam of market benefits and regulatory protections.[85] It is further noted that Federal employee "consumer satisfaction" with the program is quite high. On the other hand, some argue that the FEHBP choice program design could--with changes--be significantly improved.

If FEHBP reform is undertaken, several key administrative issues need to be addressed.

1. Monitoring and Managing the Program

At FEHBP's inception, as mentioned earlier, the environment in which health programs functioned was very different from today's. The various kinds of cost containment measures now increasingly being used by mid- and large-sized firms were simply unknown at the time to program administrators in the public and private sectors. As the decade of the '80s draws to a close, however, many believe that OPM should adopt some of these approaches.

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[85] Enthoven, A. C. *Theory and Practice of Managed Competition in Health Care Finance.* North Holland, Amsterdam, N.Y., 1988.

Also, as noted previously, there is growing support for the view that the Federal Government should use FEHBP's as yet untapped bargaining power and its immense size both to improve the health insurance value its employees receive and to increase competition--where possible--in the Nation's health care system.

If these goals are adopted, a strong role for FEHBP's administrating agency would seem to be a necessity. Even a substantially reformed FEHBP is unlikely to influence significantly the behavior of its enrollees who consume medical services or the providers who supply them if OPM or a successor is passive.

Suggestions that envision an active role by the Federal Government in monitoring and managing FEHBP include: having OPM negotiate directly with providers, as opposed to the current approach of letting the carriers play the role of middlemen; giving OPM the responsibility of setting minimum plan benefits; and, providing OPM with the resources to develop data systems capable of collecting and retrieving the kinds of information needed to effectively monitor and actively manage FEHBP.

Elaboration on the matter of data needs, for example, is instructive. Much of this information already exists within the current FEHBP structure. For the most part, however, it is not in a form that allows access, let alone analysis. Presently, data are independently gathered and analyzed by the carriers, with only summaries--at the most--being filed with OPM. For OPM to monitor and manage effectively, uniform data definition and identification need to be applied to the carriers' data bases, with the data then transferred to OPM in a prescribed format.

To alter the current system along the lines just described would impose significant additional costs and administrative burdens on all involved in FEHBP, particularly during the implementation stages. Nevertheless, there is considerable support for doing so, based on an expectation that the benefits of increased efficiency would more than offset increased administrative costs.

2. *OPM or a New Independent Agency?*

If it were decided that OPM should assume a new role as an active and aggressive administrator of FEHBP, could it do so? Does the agency have sufficient resources and expertise to undertake such vastly increased responsibilities? Some observers think that, given OPM's history of passive involvement, it would be difficult--if not impossible--for the agency to make that transition.

Further, although OPM is ostensibly an independent agency, some think that it is not sufficiently insulated from political pressures to take on the kind of "active" role discussed above. Playing a dual role of program administrator and political entity, as OPM has sometimes done under the current system, has already caused problems, critics maintain, and is likely to be troublesome in the future. For example, the policy on the level of mental health benefits has changed with different Administrations.

Consequently, recommendations have come from several quarters for creating a new independent agency to actively administer FEHBP or its successor. One suggestion, for example, calls for the creation of an independent Federal Employees Health Benefits Board to administer the program as a fiduciary for the beneficiaries of the program. The Board would be responsible for determining benefit levels, premium rates, and other financing aspects of FEHBP or its successor. In addition, the Board would actively monitor and manage the program and seek to use the buying power of FEHBP's roughly 10 million participants to encourage competition.

The answer to the question of whether OPM has sufficient statutory power depends primarily upon one's view of what role the Federal Government should play in a health insurance program for its employees. As discussed earlier in this chapter, that role can range from a minimum level of being a "passive administrator" to an all-encompassing one as a direct provider of services. But even the middle ground leaves much room for disagreement.

There are those who concur with the view of Walton Francis, author of *CHECKBOOK'S Guide to Health Insurance for Federal Employees*, that "for employee insurance, the Government role need be, and should be, no more than assuring that competing plans meet minimum standards of solvency, benefit structure, and service."[86]

Others, however, share Stanford economist Alain Enthoven's belief that OPM is too passive in its administration of FEHBP and that a "managed competition" approach is desirable.[87] It is a lost opportunity, they believe, that the Federal Government--as primary payer and sponsor of health benefits for nearly 10 million people--is not exercising its buying power in the marketplace. They think OPM (or a new agency) should have the authority and independence to create incentives to counteract alleged market failures and encourage competition, quality care, and equitable pricing. (For a discussion of large employers taking advantage of their buying powers, see the section on *Procurement of Services* in chapter 5.)

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[86] Francis, Walton. *How to Reform--and How Not to Reform--the Federal Employees Health Benefits Program.* Testimony presented to OPM. Washington, July 26, 1988. p. 5. (Hereafter cited as Francis, *How to Reform FEHBP.*)

[87] Enthoven, Alain C. *Managed Competition: An Agenda for Action.* Health Affairs, summer 1988. 23 p.

3. *Selecting and Retaining Plans*

Some think the most critical economic inefficiency in the current FEHBP design is related to plan selection: an absence of competition among plans for entry into, and retention by, the program.[88] Calling the impact on the program "devastating," the *TPF&C Report*, for example, points out that because FEHBP legislation requires "that it will do business with certain entities and only with those entities, the Government relinquishes the tremendous leverage it could otherwise exercise in the health care market."[89]

On the other hand, not everyone is supportive of the idea that the Government should be trying to influence competition by admitting plans which are judged in some way to be meritorious into the program, or turning others out.

The importance of the number of plans--particularly FFS plans--in the program is controversial. Proliferation of plans in FEHBP, some argue, compromises the Federal Government's capacity to monitor these plans to ensure that adequate quality of service is being maintained and that these plans will remain financially solvent for the foreseeable future. This situation serves neither the interests of the Federal Government nor its employees. Others, however, argue that the idea that there are too many plans is a myth, and that FEHBP should "encourage more, not fewer, plans."[90] The problems of adverse selection, for example, can occur "with any number of plan options greater than one, even in a system with one fee plan and one HMO available to each employee."[91]

4. *Communications: Providing Information to Enrollees*

Providing information to FEHBP enrollees is important for several reasons. First, if FEHBP continues to feature greater choice among plans than is found in typical private sector programs, information upon which to base a selection decision will be more vital. Second, providing FEHBP enrollees with certain types of information--information that is uniquely available to very large plans--could play a significant role in making various cost containment methods work more effectively. Finally, if FEHBP is significantly redesigned, successfully communicating the reasons for various changes to enrollees will be vital in gaining their support.

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[88] For a discussion of OPM's role in annual contract negotiations with insurance carriers see Chapter 4, *Design Features of Health Insurance Plans*, p. 4-7.

[89] *TPF&C Report*, p. 7.

[90] Francis, *How to Reform FEHBP*, p. 19.

[91] Ibid., p. 4.

With all its complexities and specialized terminology, explaining health insurance coverages is not easy. All employers, even those with single health plans, must expend significant resources to ensure even a rudimentary level of employee understanding of plan provisions. And, employers that provide flexible benefit programs find the challenge all the more difficult. They must spend considerably more time, effort and money on communications and employee education programs to assure such basic employee understanding. The task of providing FEHBP enrollees with the necessary information to make an informed choice is a daunting one. (For further discussion of OPM's efforts to communicate plan information to enrollees see Chapter 3, *Strategies for Reform*, p. 6.)

As administrator of the program, OPM is responsible for fulfilling two informational requirements under the FEHB Act:[92]

> (a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by Section 8903 of this title; and
>
> (b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the:
>
> (1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;
>
> (2) procedures for obtaining benefits; and
>
> (3) principal provisions of the plan affecting the enrollee and any eligible family members.

How can OPM best fulfill this mandate? A recent OPM evaluation of its own role in this regard--an evaluation in which it concludes that its role is inherently contradictory--is instructive:[93]

> . . . OPM as program administrator must chart a very careful course. All of the plans have met the statutory criteria for participation and presumably each has something of value to offer. Further, OPM has negotiated and signed a contract with each plan

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[92] 5 U.S.C. 8907.

[93] U.S. Office of Personnel Management. *A Study of the Adequacy of Informational Materials under the Federal Employees Health Benefits Program.* May 1986. (As required by P.L. 99-251.) p. 7. (Hereafter cited as OPM, *Study of Informational Materials.*)

> stipulating the benefits it will offer and the rate it will charge. Any hint by OPM that some plans are "better" than others, in fact, any evaluative comment at all by OPM, has the potential of giving an advantage to some plans and a disadvantage to others in the open season competition. It is a foregone conclusion that any disadvantaged plan will remonstrate against any such action or comment by OPM and would likely ask Congress to forbid it in the future. While it well may be that there is a need and a role for evaluative information, a kind of "consumer report" on FEHB, this is not a need the program administrator can fill. On the contrary, the program administrator must adopt and maintain a position of strict neutrality and allow the various plans to compete freely, intervening only to assure that the competition is fair and free of misrepresentation. **Thus, OPM finds itself in a peculiar and uncomfortable position. It has a statutory obligation to provide information to eligible enrollees so that they can make an informed decision, but the very nature of the program limits the type of information it can provide to that which is value free, which is to say, merely descriptive.** (Emphasis added)

Thus, if FEHBP reform is undertaken, it would appear to be imperative that the informational role of the administrating agency be clarified in regard to assisting enrollees in plan selection.

As to providing FEHBP enrollees with certain types of information in order to make cost containment methods work more effectively, adopting private sector approaches could prove beneficial. Mechanisms that encourage enrollees to become active and knowledgeable participants in their health care decisions, for example, are gaining in popularity. (For examples of some of these mechanisms and other cost containment methods, see Chapter 5, section D, *Descriptions of Selected Employer-Sponsored Health Benefit Plans*.)

Just as it is true that "[i]n the final analysis, a company's best defense against high [health care] costs will be a combination of employee education and behavior modification, as well as careful systems monitoring to ensure that care is being delivered in the best and most economical way possible,"[94] the success of OPM or its successor in communicating information to FEHBP enrollees could be a key element in controlling program costs.

Finally, the more clearly any reformed FEHBP can be explained, the greater will be the degree of enrollee acceptance. During the past few years, large private sector employers, in recognition of the importance of gaining enrollee acceptance, have started hiring design consultants to develop sophisticated campaigns explaining and promoting program revisions.[95] It would seem that if FEHBP is substantially changed from its present form, the Federal Government should consider following this lead.

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[94] *Employer Health Care Cost Containment*. Leonard Davis Institute of Health Economics. Factpack series, no. 10. Philadelphia, University of Pennsylvania, 1986. p. 5.

5. *Open Seasons*

> The real costs of open season have never been systematically captured. The effort within Federal agencies to distribute materials, supervise health fairs, process enrollments, etc., entails significant expenditures, but they are buried within the agencies' administrative budgets. The carriers' marketing costs fall outside their reimbursable expenses under the contract and are not centrally collected or reported . . . . The cost figure generally associated with open season ($1.4 million in fiscal year 1985) covers only printing and bulk distribution costs for OPM-provided materials. It probably represents less than half of the Government's costs and, perhaps, one fourth to one third of the total of Government and carrier costs . . . .[96]

Whatever the direct costs of open season may be, some observers have suggested that cost savings and other advantages would resu[illegible]f open seasons were held every 2 or 3 years as opposed to annually. Not only would the direct costs associated with conducting open seasons be avoided every other year or twice every 3 years, they say, but such a change would stabilize the program by reducing the severity of the problems associated with adverse selection. "The open season allows employees with specific health concerns (i.e., elective surgery, planned hospital admissions) to select those plans which offer the richest benefits for those conditions . . . ."[97]

Such a change would also permit OPM to devote more of its time and energies to other administrative areas. And, it would have a beneficial side effect in connection with cost containment efforts, since most such efforts require keeping pressure on both providers and consumers not to overuse the system; such pressure is less effective if an escape valve is frequently opened.[98] Other possible benefits include:

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[95] Ibid., p. 37.

[96] OPM, *Study of FEHBP Informational Materials*, p. 14.

[97] Letter to OPM from Metropolitan Life Insurance Company. In, *TPF&C Report*, appendix A.

[98] U.S. Congress. House. Committee on Post Office and Civil Service. Subcommittee on Compensation and Employee Benefits. Federal Employees Health Benefits Reform Act of 1983. Hearings on H.R. 656, 98th Cong., 1st Sess., June 21, 23, 28, July 26, 28, and Aug. 4, 1983. Washington, U.S. Govt. Print. Off., 1983. Testimony of Blue Cross and Blue Shield. p. 250.

- Improving the quality of various types of data collection by increasing the time periods involved. In particular, it would improve carriers' cost projections by permitting them to develop more credible experience with their current participants;

- Ameliorating the problems associated with slow processing of enrollment forms, including determining eligibility for benefits following an open season;

- Improving benefit and rate negotiations by extending the deadlines during nonopen season years from May 31 until sometime in the fall.

If the frequency of open enrollments were reduced, it would appear necessary to require that carriers negotiate rates to cover the periods between open enrollments.

Those who advocate remaining with an annual open season contend that the risk selection process would be only marginally affected by such a change, the lengthening of projection periods would compromise the accuracy of the projections, and FEHBP enrollees would be disadvantaged compared to private sector employees who usually get to make choices every year between FFS plans and HMOs.

> Employee choice is one of the central features of the FEHBP and it is imperative that Federal workers have the opportunity to opt out of a plan they are dissatisfied with. In addition, federally qualified HMOs are required to have an annual 30-day open enrollment period--no waiver is permitted for Federal enrollees. Finally, if reforms are made to the program, continuing an annual open season will enable the impact of such reform to appear more rapidly.[99]

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[99] U.S. Congress. House. Committee on Post Office and Civil Service. Subcommittee on Compensation and Employee Benefits. Federal Employees Health Benefits Program. Hearings, 100th Cong., 2d Sess., May 11 and 18, 1988. Washington, U.S. Govt. Print. Off., 1988. Testimony of Group Health Association of America (GHAA). p. 57.

CHAPTER 9. PREMIUM COSTS AND FINANCING

- **Over the last 9 years, total premiums per FEHBP enrollee would have had to increase by an additional 19 percent to reach the growth experienced by private employer plans. A large part of the difference derives from the 1982 FEHBP benefit reduction mandated by OPM.**

- The experience-based approach used to set FEHBP premiums and the Government's premium-sharing formula has contributed to two effects:

    - High-risk FEHBP participants are now concentrated in a handful of high-benefit options; and

    - The Federal share of total premiums has risen significantly. In 1982 it was 60 percent and in 1989 will reach 71 percent.

- Unlike private firms, the Government requires FEHBP enrollees to bear a considerable portion of their premium costs. Adopting the premium-sharing practices used by private employers would raise the Government's share of premiums to an estimated 87 percent.

A. Introduction

Concerns have mounted that FEHBP premiums are too high and are increasing too rapidly. In 1989, total spending for FEHBP premiums will reach $11.6 billion. On average, premiums have risen by over 20 percent during each of the past 3 years. Some analysts question whether increases of this size were necessary and argue that future increases be curtailed. This chapter explores reasons for recent increases by analyzing the nature of FEHBP premium costs, the process of setting annual premium rates, and alternate means of determining the share of premiums paid by the Federal Government and by FEHBP enrollees. It focuses on the following questions:

- How do increases in FEHBP premiums compare with general measures of inflation in medical care costs and with increases in the cost of health insurance plans offered by private employers?

- What premium savings might result from curtailing FEHBP administrative and other overhead expenses and from consolidating FEHBP reserves, now maintained on a plan-by-plan basis, into a single unified account?

- What premium-sharing alternatives might be considered for FEHBP financing?

B. Costs of FEHBP Premiums

1. *Background*

To understand recent trends in FEHBP premium increases, it is important to note two major adjustments in FEHBP premiums that have occurred since 1980. The first, beginning in 1982, resulted from an OPM mandate. In order to avoid what were viewed as unprecedented increases in premium rates, OPM required that the fee-for-service (FFS) plans participating in FEHBP reduce their 1982 benefits by 13 percent. The ensuing across-the-board implementation of annual deductibles and coinsurance rates halved what would have been an average 1982 premium increase of 35 percent. As a result, the enrollees' value of FEHBP benefits was permanently reduced.

The second event, initiated by Blue Cross/Blue Shield (BC/BS), culminated in a $1 billion rebate, plus an average 1986 reduction in FEHBP premiums of 11 percent. It evolved from questions raised early in 1985 concerning the amount of FEHBP reserve funds held outside the U.S. Treasury and managed by BC/BS and, to a lesser extent, concerning reserves held by other plans. Subsequently, Blue Cross and 10 other FEHBP plans elected to rebate $1 billion in reserves ($600 million to the Government and $400 million to enrollees). In addition, most of these 11 plans reduced their 1986 premiums. Other plans, including NAGE and Mail Handlers, applied all of their extra reserves to reduce 1986 premiums.

A group of individuals, most of whom had been enrolled in BC/BS High Option prior to 1985, sued for a portion of the rebate. As their prior-year premiums had contributed to the buildup of excess reserves, they argued, a portion of the rebate should be theirs. The court disallowed their claim, and all of the rebates were distributed based on the 1985 FEHBP enrollment.

During the 1985 open enrollment period, some persons transferred to those benefit options that chose to lower 1986 premiums rather than to provide rebates. The combined enrollment for Mail Handlers and NAGE, for example, increased by 9 percent, from 457,000 to 499,000. Obviously, the 1986 premium reductions induced some enrollment shift. To the extent that more enrollees transferred to or elected to remain in lower-cost plans, the program-wide value of FEHBP benefits and thus of premium costs were lowered. The drawing down of reserves, however, did not affect the underlying cost of FEHBP insurance.

2. *Premium Cost Allocations: Why Spending Increased*

Between 1980 and 1989, FEHBP premium spending more than tripled--growing from $3.7 billion to $11.6 billion. To what extent did the $7.9 billion increase result from higher prices for medical services, more enrollees and increased health care consumption--commonly referred to as utilization? It is difficult to allocate precisely the rise in FEHBP premiums among these factors. First, some of the variables interact with one another, and thus the effects cannot be completely isolated. (Given higher out-of-pocket costs for FEHBP premiums, for example, enrollees may move to lower-cost plans, including HMOs that tend to moderate the consumption of health care services.) Second, variables like the national rate of inflation in medical prices do not neatly apply to the particular distribution of hospital, physician and other health care services consumed by FEHBP participants. Third, premiums are also affected by other events. Examples include the previously noted 1982 cutback in FFS benefits, and the advent in January 1983 of mandatory Medicare coverage for Federal workers. Over the long term, both of these events reduce the cost of FEHBP premiums. Atypical events like premium rebates and the use of premiums to build up reserves (either as offsets for past estimating errors or for unforseen future costs) only affect the year-by-year levels of premium increases and not the value of benefits provided.

Given these qualifications, the rise in general prices for medical care services represents the single largest factor driving FEHBP premiums, accounting for nearly half the premium increase since 1980. If enrollment, benefit levels, and utilization patterns had remained constant (see figure 9.1), premiums would have doubled rather than tripled. In this context, price increases for medical services since 1980 have added some $3.7 billion to 1989 rates.

Figure 9.1 also illustrates that enrollment growth since 1980 explains about 15 percent, or $1.2 billion, of the total $7.9 billion increase. Higher costs attributable to FEHBP enrollment changes derive mainly from the steady climb in the sheer number of annuitants. The number of FEHBP enrollees has climbed since 1980 from 3.6 million to 4.0 million. Most of this growth reflects the steady rise in the number of FEHBP-covered annuitants (net increase of 320,000). Increases in postal employment since 1984 have added about 120,000 more enrollees. In response to workforce reductions occurring prior to 1985, however, the number of nonpostal workers covered by FEHBP has declined slightly.

The balance of the 1980-1989 premium increases (nearly two-fifths) represents $3 billion of the $7.9 billion rise. Some of the increase undoubtedly reflects higher utilization patterns, especially for older enrollees.[100] Other factors have both dampened and increased premiums. The advance of medical technology has in some cases led to more efficient and less costly delivery of services but in other cases has produced new and more costly treatment options that simply were not available in earlier years.

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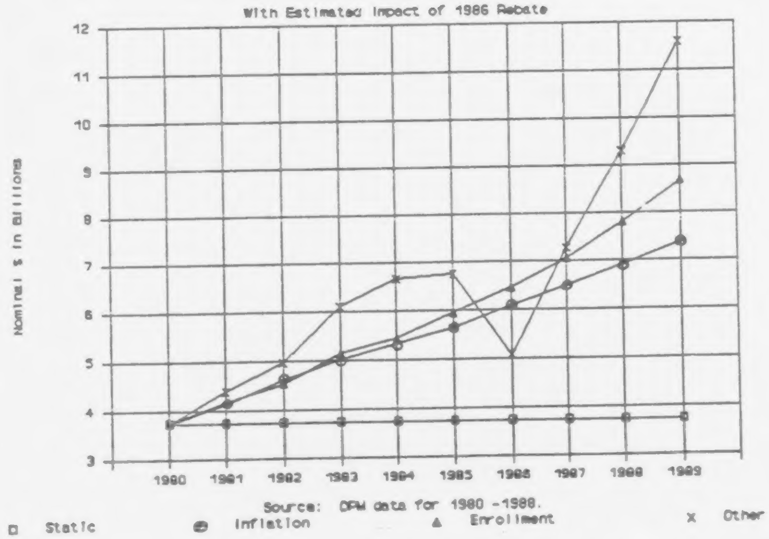
[100] Greater health care consumption by annuitants is not by itself an accurate predictor of FEHBP premiums. As described in chapter 7, annuitants participating in FEHBP use more medical care services, but they generate larger medical care costs for FEHBP plans only until Medicare coverage begins.

FIGURE 9.1 Allocation of Increases in Total FEHBP Premiums Among Price Increases for Medical Care Services, Higher Enrollment, and Other Factors



Source: OPM data for 1980 -1988.

3. *FEHBP Premiums in the 1980s*

Annual FEHBP premium rates per enrollee provide a convenient yardstick to measure systemwide costs. The estimated $11.6 billion of 1989 spending for FEHBP represents a per-enrollee average of $2,890. When compared to the 1980 average of $1,040, annual per-enrollee increases in FEHBP premiums during the last 9 years have averaged 12 percent. The analogous private sector increase is about 14 percent. To have matched the accumulated private sector level (assuming 1980 values were the same), FEHBP premiums would have had to increase by an additional 19 percent. Much of the difference results from the 1982 benefit reduction mandated by OPM, which avoided an average increase in FEHBP premiums of about 15 percent.

Private firms have also taken steps to help dampen growth in their health insurance expenditures. Some, for example, have increased the size of the annual deductible; nonetheless, the typical FEHBP deductible for FFS plans is even higher than that of the typical private plan. Unlike FEHBP, private firms have also introduced aggressive cost control programs, financial incentives, and physical fitness programs to help encourage workers to improve their health. They have devoted substantial resources to employee communication and health education.[101] Despite these efforts, the rise in private-sector premiums during the 1980s exceeds FEHBP's. One explanation is the rise in Federal enrollee coinsurance rates and annual deductibles coupled with declines in FEHBP benefits, especially for dental and mental health care. In addition, Federal enrollees have taken advantage of the choices offered them by moving to lower-cost plans in order to escape rising premiums.

Increases in the average enrollee's FEHBP premiums in the early 1980s outpaced the yearly rise in overall prices for health care services (see table 9.1). In 1985, however, premium adjustments overtook and surpassed medical care inflation. As a result, annual average increases through 1986 show medical inflation at 9.6 percent versus FEHBP increases of 7.4 percent. The post-1986 relationship is quite different. The average annual rate of medical care inflation has eased to an estimated 7 percent. Meanwhile, FEHBP premiums averaged over the last 3 years have increased annually by more than 20 percent. Given the 1982 cutback in FFS benefits and the 1986 draw down of accumulated FEHBP reserves, the year-to-year change in FEHBP premiums understandably differs from that of the private sector. Such a comparison, however, focuses only on the rates of change rather than on the amounts spent on health insurance premiums.

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[101] Innovative health care practices adopted by private as well as public employers are discussed in chapter 5.

TABLE 9.1. Changes in Average Premiums Per Enrollee (FEHBP and Private Sector) and in the Price of Medical Services, 1980-1989

Year	FEHBP premiums[a]	Price increases[b]	Private sector premiums[c]
	Index: 1980 = 100		
1980	100.0	100.0	100.0
1981	115.4	110.7	117.0
1982	135.4	123.8	136.9
1983	159.2	134.5	173.6
1984	175.0	142.6	203.6
1985	172.9	151.3	211.3
1986	153.2	163.0	217.3
1987	180.0	173.7	235.9
1988	226.5	185.0	275.8
1989[d]	278.4	198.0	331.0
	Year-to-Year Percent Changes		
1981	15.4	10.7	17.0
1982	17.3	11.8	17.0
1983	17.6	8.7	26.8
1984	9.9	6.0	7.3
1985	-1.1	6.1	3.8
1986	-11.4	7.7	2.8
1987	17.5	6.5	8.6
1988	25.8	6.9	16.9
1989[d]	22.9	7.2	20.0

[a] Developed from unpublished OPM data for 1980-1988.

[b] Price increases as measured by the medical care component of the Consumer Price Index.

[c] Data developed by Hay/Huggins Company, Inc. from employer-reported data that, in some cases, exclude costs for retirees. Unlike FEHBP, some private firms separate workers' and retirees' health insurance costs.

[d] Increases estimated for 1989, based on the FEHBP Model that projects shifts in enrollment among FEHBP plans. See appendix A.

Differences in a variety of factors affect health insurance costs. Some private firms separate the health insurance costs for retirees and active workers--even though the annual premium changes for the two groups should be almost the same since the higher costs associated with retirees are offset by lower costs due to amounts paid by Medicare.[102] Other factors that affect premium comparisons between FEHBP and private sector health plans include variations in the medical services that the respective insurance plans cover or exclude, and in the average amount of health care services consumed by the plan participants. Some of the differences in health care utilization are reflected in the demographic profile of the insured population. Relative to their effect on premium costs, the most important demographic characteristics of FEHBP enrollees are age and Medicare coverage. Premium costs, as a general rule, increase with age until Medicare coverage begins.

Compared with participants in health insurance plans maintained by medium to large private firms, Federal workers covered by FEHBP are slightly older, and Federal retirees are much less likely to be eligible for Medicare coverage.[103] Also, as indicated in table 9.2, FEHBP premiums may be distributed much differently from those of some private firms regardless of the cost differences attributable to demographic characteristics. This occurs because FEHBP pools rather than segregates the insurance risks of active and retired workers. Consequently, both Federal workers and Federal annuitants covered by Medicare help support the much higher costs of FEHBP annuitants without Medicare coverage (see chapter 7). Without regard to the policy questions that would be raised, separating Federal workers from Federal annuitants would transfer $0.9 billion of premium charges from one group to the other. The more pertinent question, however, is how the total premium cost would be distributed between the Federal Government and FEHBP enrollees. Some analysts have suggested the alternative method of using the demographic characteristics for certain groups of enrollees to adjust premiums as measured against a program-wide average. The rationale and the potential difficulties that would accompany such a "risk-adjusted" approach to premium setting are discussed at the end of this chapter.

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[102] For typical private plans, the health insurance costs for enrollees with Medicare coverage are comparable to those for enrolled workers.

[103] Since January 1983, Federal employees pay the Medicare payroll tax and generally qualify for Medicare coverage at age 65. Unlike the private sector, however, a substantial portion of Federal workers retire prior to age 60. In particular, the youngest third of each year's new pensioners has a median age of 54.

TABLE 9.2. FEHBP Premium Spending for 1989 Under Current and Alternate Demographic Assumptions
($ in billions)

Assumptions	FEHBP employees	FEHBP annuitants	FEHBP total
Current system and demographics	7.0	4.6	11.6
Assuming current demographics but separate plans for workers and for annuitants	-0.9	0.9	0
Assuming private sector demographics for workers	-0.2	n.a.	-0.2
Assuming private sector demographics and Medicare coverage for annuitants	n.a.	-1.4	-1.4
Total: Assuming private sector demographics and Medicare coverage	5.9	4.1	10.0
Net difference	-1.1	-0.5	-1.6

Source: Prepared from demographic factors developed by the FEHB Team, see appendix A, part c.

4. *Cost Impact on FEHBP of Adopting Private Sector Benefits and Premium-Sharing Arrangements*

Another way to examine the differences in premium costs between FEHBP and private sector health plans is to estimate the impact on FEHBP premiums of adopting private sector benefits and premium-sharing arrangements. Adopting health insurance benefits typical of the private sector could increase FEHBP premiums by 21 percent.[104] The richer benefits provided by private firms would account for about 16 percent of this premium increase. The remaining 5 percent of the increase would derive from a potential 11 percent rise in FEHBP enrollment levels if some 450,000 Federal workers who currently waive FEHBP coverage were drawn into FEHBP by the more generous premium-sharing practices. The actual enrollment increase would depend, of course, on the specific eligibility criteria and financing arrangements adopted by the Government and on how effectively the change was communicated to Federal workers.

Workers in the private sector, on average, enjoy richer health insurance benefits than their Federal counterparts. In addition, private employers typically guarantee Self Only coverage for all workers by paying 100 percent of the premium. But the private-Federal disparity in health benefits may be changing as private employers require more premium payments from enrollees and possibly make changes in annuitant coverage. In the future, private firm coverage for annuitants' health benefits could be curtailed in response to the Medicare Catastrophic Coverage Act and to new financial standards requiring the recognition of long-term liabilities. (Detailed discussions regarding differences between the benefit provisions and the treatment of annuitants by FEHBP and by typical private firms are provided in chapters 5 and 7, respectively.)

The current FEHBP includes 2.48 million Federal workers, 1.25 million Federal retirees, 0.28 million other annuitants (survivors of a former Federal employee), and about 5 million dependents.[105] About 150,000 Federal workers and retirees are uninsured, that is, without any health insurance coverage.

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[104] This estimate is based on differences between "pure premiums" for FEHBP and private benefit provisions. It was determined without regard to differences between allowances for reserves and for administrative overhead costs, including State premium taxes and profits. The estimates also assume that private annuitants will remain covered by the same benefit provisions as active workers--even after they qualify for Medicare.

[105] The eligibility and dependent estimates were derived from OPM data and from the Current Population Survey (CPS) data collected as of March 1988. FEHBP data currently collected by the Government are limited and do not contain information about demographic characteristics or the number of dependents enrolled in the program. The estimated number of potential dependents (6.4 million) may be understated because the CPS does not cover the institutionalized population.

As a general rule, workers covered by a Federal retirement program are eligible for FEHBP coverage. Of the 2.9 million Federal workers now eligible, about 85 percent participate.[106] This leaves some 450,000 "potentially insured" workers who could join FEHBP if the Government financed 100 percent of Self Only coverage. The eligibility requirements for Federal retirees are more involved. In general, Federal employees may continue their FEHBP coverage upon retirement if they have participated continuously for the 5 preceding years. But if they stop FEHBP coverage after they retire, coverage cannot be reinstated. About 78 percent (or 1.25 million) Federal retirees now participate in FEHBP. Just over 80,000 are ineligible because they did not retire, but left Federal service entitled to a deferred annuity (beginning at age 62). The remaining 270,000 ineligibles either discontinued coverage after they retired, or did not satisfy the continuous service criterion.

C. Rate Setting

1. *Background*

The FEHBP is financed by setting annual premium rates for two different types of plans: fee-for-service (FFS) plans that cover about three-fourths of FEHBP enrollees, and prepaid (HMO) plans.[107] OPM requires that the premiums charged by FFS plans reflect their claims-cost experience. That is, any losses resulting from insufficient rates are rolled forward and recouped in premiums set for subsequent years. Community-rated plans, on the other hand, base their premiums on the claims-cost experience of all participants, Federal and nonfederal alike. Most HMO plans participating in FEHBP use community-based rates; the remainder use experience-based ratings.

2. *Anatomy of FEHBP Premiums*

As the program's administrator, OPM is responsible for the establishment of premiums for FEHBP options. Each premium rate, regardless of whether it is experience-based or community-based, consists of three parts: a **subscription income** requirement to cover each plan's claims and overhead costs; a **contingency reserve** margin for unforeseen cost increases, set at 3 percent of subscription income; and an **administrative reserve** charge, set at 1 percent of subscription income, which is used to finance the expenses incurred by OPM as program administrator.[108]

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[106] These estimates exclude the temporary Federal workers who may elect FEHBP coverage but must pay 100 percent of the premium.

[107] See detailed discussion in chapter 2 on health insurance principles and rate setting.

[108] The contingency and administrative reserve factors can be lowered administratively by OPM. The law only sets the maximum rates, which are the same as the 3 percent and the 1 percent levels currently charged by OPM.

Estimated subscription income in 1989 for all FEHBP plans, FFS and HMO alike, totals $11.2 billion. It is not yet known whether this amount will lead to a year-end surplus or deficit. Some of this income, however, will be used to compensate for deficits realized in 1987, and perhaps in 1988 as well.[109] If the 1989 premiums prove reasonable, payment for medical claims should total about $10.4 billion, or about 92 percent of subscription income.[110] Based on the 1987 results, the remaining 8 percent or so covers the following overhead costs: $0.7 billion for administrative expenses; $0.1 billion for service charges that are mainly profits; and $0.05 billion for State premium taxes.

The subscription income amounts charged by community-based HMO options are not negotiated. But OPM does determine if the HMO's rates for private employers vary from those charged FEHBP enrollees. In some instances, HMOs have attempted to justify lower rates for private firms by using modest copayment requirements or curtailing certain benefits. When apprised of this situation, OPM has taken the position that the HMO's lowest rate is the community rate. Unless the HMO can justify the higher rates charged FEHBP enrollees, it must refund excess FEHBP contributions.

Premium rates for FFS options are set through annual negotiations between OPM and the FEHBP plan sponsors. Each year, starting in late spring and generally extending through much of the summer, OPM and the sponsors' representatives negotiate premiums for the following calendar or "contract" year. But the medical service cost data that underlie each negotiation is generally 2 years old. Thus, the experience-rating approach is driven more by recent trends than it is by current cost data.[111]

Experience rating coupled with the Government's premium-sharing formula has contributed to the segmentation of insurance risks, and to the concentration of high-risk enrollees in certain high-option FFS plans. Assume, for example, that an employer introduces a FFS choice between a high option and a standard option, decides to use experience rating to determine premium rates, and requires participating employees to pay 30 percent of the total premium. In the first year, the standard option attracts a number of younger and lower-paid enrollees who want to minimize their premium payments. After a few years, more and more of the "healthier risks" have enrolled in the standard option. Relative to the standard option, the total premium of the high option is driven up, and fewer and fewer enrollees are willing to pay the higher premium charge. Eventually, the high option plan would be left covering the truly sick and the misinformed who believe they are getting back more in benefits than they are paying in. In theory, the ever-higher premiums caused by the combination of experience rating and the Government's premium-sharing formula could methodically deplete one FEHBP high-option plan after another.

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[109] FEHBP financial statements for 1988 will not be available until early 1990.

[110] The portion of subscription income used to finance enrollees' medical expenses is often referred to as the "pure premium" or the "pure cost" of the plan.

[111] Negotiations take into account the expected inflation rate for medical service and utilization trends. OPM and the plan sponsors might also negotiate the possible cost effects of enrollment transfers during the upcoming open season.

Most FFS plans can respond to this premium cost spiral because they are not required to offer and maintain two levels of benefits, a high option and a standard option. When a high option becomes over-subscribed by high-risk enrollees, the plan could encourage transfers to its standard option and then discontinue the high option. This approach, however, cannot work for Aetna and for BC/BS because the law requires that they maintain two levels of benefits. (The premium cost spiral is discussed at some length in chapter 6.)

3. Insurance Risk

If any FFS plan were to withdraw from FEHBP in a deficit position, its participants would be able to enroll in another plan. Generally such participants would not be at risk because FEHBP requires that plans cover preexisting medical conditions after enrollment changes. But what of the plan and its sponsors?

Losses experienced by FFS plans because of insufficient premiums in prior years are recouped through higher premium rates in subsequent years. However, a plan might not be able to raise its subsequent year's premiums high enough to recoup a shortfall and still remain competitive with other FEHBP plans. In this circumstance, a plan might be forced to default. Realistically, there are ways that FFS plans other than Aetna and BC/BS could avoid such plans default, as discussed above. Most would argue that such plans have little, if any, exposure to insurance risk. BC/BS has been able to maintain its market share by encouraging enrollment in its Standard Option; Aetna has not experienced similar success. After several years of consecutive FEHBP losses, Aetna has responded by replacing its "reasonable and customary" approach to reimbursement for medical service charges with a fixed reimbursement schedule. It is unclear if this will resolve the problem, or if Aetna will need to take other action.

From the perspective of those who sponsor FFS plans, there is always the possibility that FEHBP might be changed and the number of benefit options significantly reduced. Depending on the time and the circumstances, some plans excluded from the new program might have experienced a year of extremely large losses and would not be able to recoup them.

4. *Overhead Charge Disparities*

OPM also negotiates contract-year payments for each option's overhead costs, including the plan's administrative expenses and its service charges (or profits). Plan payments for State premium taxes reflect the actual charges paid by the plans based on the respective number of FEHBP enrollees.

a. Administrative expenses, measured as a percentage of subscription income, are growing. Administrative costs for FFS plans averaged about 6 percent in 1987 and ranged from a low of 4 percent of subscription income (Aetna's High Option) to a high of 12.7 percent (NAGE's Standard Option). In 1989, the administrative expenses are estimated to exceed 7 percent of subscription income. Obviously, curtailing administrative expenditures could moderate premium rates. But more resources may be needed in this area rather than less.

OPM's resources for reviewing FEHBP programs are limited. More important, however, they focus on the amount that FFS plans spend on overhead costs rather than on the $9 out of $10 they pay for medical services. Because the FEHBP contracts do not contain any common plan criteria or minimum requirements, quality control and program evaluation efforts vary from plan to plan. OPM can, of course, adjust a plan's service charge (profit level) in response to enrollee complaints about poor claims processing.

b. Service charges are essentially profits, vary among plans, and are set by OPM. Service charges are limited by OPM to less than 1.1 percent of a plan's subscription income. The average service charge received by FFS plans in 1987 was 0.5 percent of subscription income, and ranged from 0.3 percent (NALC) to 1.0 percent (Secret Service). It is difficult to assess whether this approach is prudent or desirable. Large plans, in theory, should be more efficient claims processors than smaller plans. If so, the current situation should encourage firms to compete for a larger market share. But under FEHBP, plans whose market share is composed of high-risk enrollees will be penalized by the resulting higher premiums which, in turn, will force the good risks to transfer enrollment.

c. State premium tax payments exceed service charges (profits) for some FEHBP plans by substantial amounts. States collect premium tax payments from most FFS plans participating in FEHBP. Aetna paid nearly $11 million in State premium taxes in 1987, for example, and earned FEHBP service charges (profits) of $5 million. Other plans pay no State taxes. As employee organizations that self insure their FEHBP insurance plans, the GEHA, NALC and APWU plans pay no State premium taxes. Exempting all FEHBP plans from State premium taxes would reduce annual premiums (and concomitantly resources available to State governments) by only $50 million.

5. *Reserves*

Reserves serve as a hedge against an unforeseen rise in claim costs. The FEHBP premium rates for all FFS and HMO plans incorporate, in order to accumulate **contingency reserves**, an add-on equal to 3 percent of subscription income.[112] Because they essentially process claims (unlike HMOs that supply medical services), FFS plans also maintain **accrued claims** (which are accounts payable) reserves. The accounts payable reserves result from the lag or "float" between the receipt and the payment of a claim. Investment earnings realized on reserves for FFS plans are FEHBP assets.

a. Recent reserve change. Prior to 1989, some of the contingency reserves for FEHBP plans with experience-based premiums were managed by the respective plan sponsors rather than by OPM. This led to several problems concerning how plans were using these funds, including charges of fraud and abuse. In some instances, FEHBP monies were commingled with other funds or used for purposes unrelated to health insurance.[113] In other cases, the investment returns generated by some plans were extremely small or even negative. Partly in response to these concerns, OPM established a letter-of-credit (LOC) arrangement for FEHBP. This arrangement, effective January 1989, will result in the Government holding nearly all of the FFS plans' contingency and accrued claims reserves. Not only will the LOC approach minimize the need for OPM to monitor the management of FEHBP funds, but it will also improve the Federal Government's cash flow.

Under the LOC approach, OPM will continue to earmark contingency reserve funds for individual carriers instead of maintaining a single unified reserve account. Continuing the current plan-by-plan approach will likely result in higher reserve levels than if a single account were used. Because the need to use these reserves varies each year and among plans, some carriers could have significant reserve levels while others might be underfunded. Another area not addressed by the LOC reform is how to determine the appropriate amount of FEHBP reserves.

b. Reserve size. It is not clear how large contingency reserves should be or, depending on the number and type of FEHBP plans offered, whether they are necessary at all. Under the current financing arrangement, contingency reserves, as estimated by OPM for October 1989, total about $1.1 billion, or nearly 10 percent of subscription income. About two-thirds of this amount derives from Federal premium contributions.

If contingency reserves were pooled rather than maintained on a plan-by-plan basis, a level of around 6 percent of subscription income might prove adequate.[114] The surplus resulting from liquidating some or all of the contingency funds could be used to moderate future premium increases. The majority of private firms limit reserves for their FFS plans to the float between the receipt and payment of claims. In addition to these accrued claims reserves, some private plans also maintain certain contingency reserves, often equal to an extra month's claims.

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[112] Reserves equal to 3 percent of subscription income represent less than half of one month's payments for medical claims. As can be seen by the 1986 rebate, however, reserves can build up substantially over time.

[113] GAO is reviewing the past use of FEHBP reserve funds.

D. FEHBP Premium Sharing

1. Who Pays for FEHBP

Participation in FEHBP is voluntary. To help finance the program, the law requires the enrollee to pay, on an after-tax basis, part of the health care premium. The enrollee's share is simply the difference between the total premium and the amount paid by the Federal Government as employer or former employer.

The Federal Government's share is determined independently for Family and for Self Only coverage. By law, the Federal contribution is based on a two-part formula, generally referred to as the Big Six formula. The first part of the formula limits the Government contribution to a flat dollar amount equal to 60 percent of the average premiums for the high-option benefits offered by six selected plans.[115] The second part of the formula further limits the Government's contribution to 75 percent of the premium for the particular option selected by the enrollee. (The two limits on agency contributions for postal workers are determined through collective bargaining and are currently a fourth higher: a flat-dollar amount equal to 75 percent of the Big Six formula and no more than 93.75 percent of any option's premium.)

2. Premium Sharing

a. Background. To a large extent, enrollees transfer among FEHBP benefit options to reduce their out-of-pocket costs, especially those for FEHBP premiums. Indications that support this view include: the number of enrollees who have left the high options offered by BC/BS and Aetna; the continuing growth in FEHBP enrollment for HMOs; and the substitution, described below, of the two plans that represent employee organizations in the Big Six formula.

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[114] For a discussion of alternate reserve requirements, see General Accounting Office, Opportunities for Improving Administration of Government-wide Indemnity Benefit Plan of Health Insurance for Federal Employees and Annuitants, 1972 and Congressional Budget Office, Reducing the Reserves of the Federal Employees Health Benefits Program, June 1981.

[115] The law specifies that the six plans used to determine the Government's FEHBP contribution are the two nationwide plans (Aetna and Blue Cross), the two largest HMOs (the Kaiser plans for Northern and Southern California), and the two largest employee organization plans (since 1984, GEHA and Mail Handlers). Size is determined by a plan's total enrollment.

Between 1980 and 1989, enrollment in the BC/B and Aetna High Options declined from 1.8 million to 0.3 million. Measured as a share of overall FEHBP enrollment, these two high-benefit options have plummeted from nearly 50 percent of the market to less than 8 percent. During this same period, enrollment in prepaid plans has grown from 0.3 million to an estimated 1.1 million.

The Mail Handlers replaced the more expensive APWU as one of the Big Six plans in 1982. As a result, the maximum Government contribution for 1983, based on 60 percent of the Big Six average, was 5 percent less than it otherwise would have been. In response, the Congress legislated an additional Government payment for calendar year 1983. This one-time increase restored the Government's 1983 contributions, on an option-by-option basis, to the level that would have occurred had APWU remained as one of the Big Six plans.

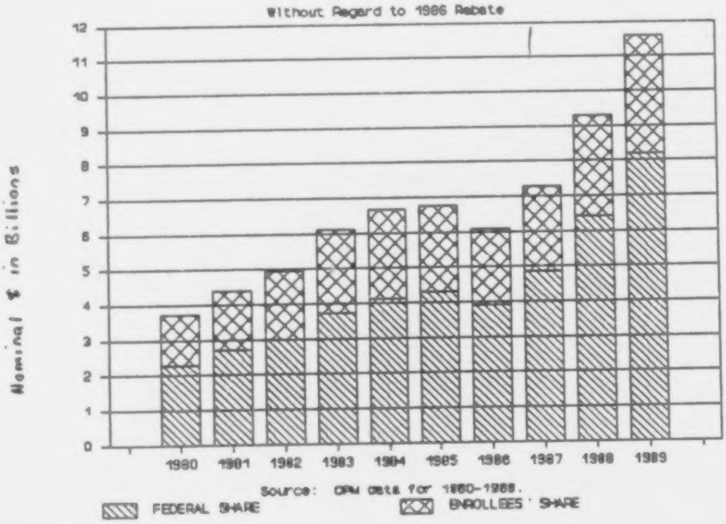
When GEHA replaced the NALC in 1983, the combined effect of this substitution in the Big Six formula and related enrollment transfers reduced the 1984 total premium for the average FEHBP enrollee by $100. Given a 1984 enrollment of 3.6 million, the total FEHBP premium costs were effectively reduced by $360 million.

b. Impact on the Enrollees' Share of Premiums. The Government's premium-sharing formula has resulted in Federal employees--excluding postal workers--paying an average of 29 percent of FEHBP plan premiums. This percentage varies by plan, however, because of the substantial differences in total premiums among plans and because the Federal payment is essentially a fixed dollar amount. Thus, those who have continued to participate in certain high option plans have seen their share of FEHBP premiums rise to 60 percent, twice the systemwide average. In addition, the year-to-year increase in total premiums for certain high option plans is much greater than the program-wide average. In particular, the 1989 premium increases for the high options offered by Aetna and Blue Cross, which represent one-third of the Big Six formula, averaged more than 40 percent.

Given the double-digit increases in FEHBP premiums, many FEHBP enrollees seek benefit options that require smaller enrollee contributions. As a result, the portion of total FEHBP premiums paid by enrollees and by the Federal Government has changed. In 1982, the Federal share was 60 percent. Including the estimated effect of the 1988 open enrollment period, in 1989 it is expected to reach 71 percent (see figures 9.2 and 9.3).

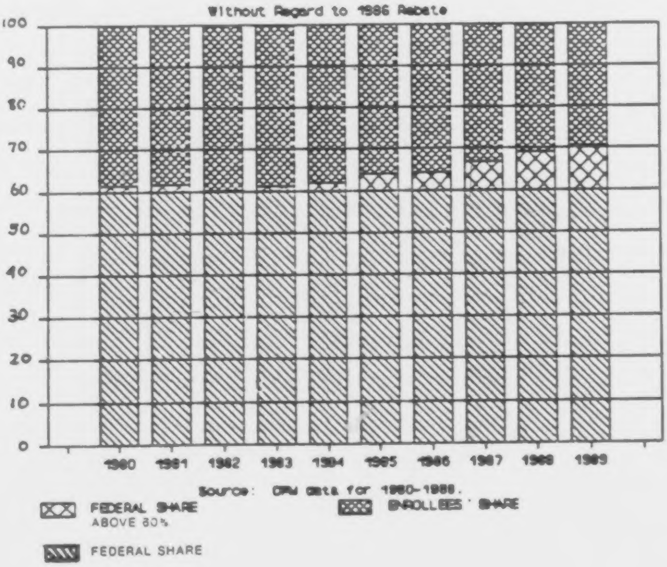
FIGURE 9.2. Cost of FEHBP Premiums Paid by the Government and Enrollees, 1980-1989 ($ in billions)

Without Regard to 1986 Rebate



Source: OPM data for 1980-1988.

FIGURE 9.3. Comparison of the Portion of FEHBP Premiums Paid by the Government and Enrollees, 1980-1989



Source: OPM data for 1980-1988.

The use of FEHBP-wide averages masks a considerable amount of variation among groups of FEHBP enrollees. As a rule, the average share of FEHBP premiums paid by the Government for workers, excluding postal employees, approximates the Federal share of program-wide premiums.[116] This occurs despite the higher average share of FEHBP premiums paid by the USPS on behalf of its active work force, which now exceeds 87 percent. The reason, as illustrated in table 9.3, is that Federal contributions for annuitants as a group average 62 percent. In particular, the relatively large number of annuitants who have elected to remain in the high options of Aetna and Blue Cross now pay about 60 percent of their annual premiums.[117] The law limits only the Federal contribution; it does not limit the enrollee's share by establishing a minimum Federal percentage that would apply regardless of the total cost of the selected FEHBP option.

c. *Premium-sharing practices of private firms.* The private sector has not solved the problem of containing the rise in health care costs, but apparently a lot more private resources are devoted to managing health insurance programs than the Government spends to manage FEHBP.[118] While some employers are trying to shift more and more of the health-care premium costs to the enrollees, most large firms continue to pay 100 percent of the plan's premium for covering just the employee, and about 75 percent of the additional cost to cover dependents.[119] Adopting health care practices representative of private firms would increase the Government's share of FEHBP premiums, based on 1989 enrollment levels, from 71 to 87 percent. This would raise 1989 Government contributions, given current FEHBP benefit and enrollment levels, by $1.9 billion.

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[116] The Federal share of FEHBP premiums for nonpostal employees tracks the steady rise in the Government's share of systemwide costs exhibited in figure 9.3.

[117] Remaining in certain high option plans is extremely costly. The 1989 enrollee share of annual premiums, excluding postal workers, for Aetna and BC/BS High Options will exceed $2,000 for Self Only, and $3,800 for Family.

[118] As the administrator of FEHBP, OPM is allocated $112 million for 1989 administrative expenses. In recent years, spending has been limited to about one-tenth of the 1 percent of subscription income set aside for these purposes. In the private sector, where choice is generally limited to three or fewer FFS options, spending on analogous costs ranges up to 3 percent. See *President's Private Sector Survey on Cost Control*, Report on Personnel Management, Nov. 1983. p. 60.

[119] According to the *1988 Hay/Huggins Benefit Survey*, 57 percent of private firms pay all of Self Only coverage and 32 percent pay all of the additional costs for dependents. The same financing arrangement is assumed to apply for retirees and their dependents, but the employer's cost drops significantly when Medicare coverage begins.

TABLE 9.3. Estimated Change in FEHBP Premium Costs and Contributions, 1988-1989 (costs in billions of $; shares in %)

	Postal workers	Nonpostal workers	Annuitants	FEHBP total
Premium Costs and Contributions for 1988 and 1989				
1989 Total costs:	2.1	4.9	4.6	11.6
Federal share	87.3	71.0	62.3	70.6
Enrollee share	12.7	29.0	37.7	29.4
1988 Total costs:	1.7	3.9	3.7	9.3
Federal share	84.7	69.3	61.4	69.0
Enrollee share	15.3	30.7	38.6	31.0
Increases from 1988 to 1989				
Total cost	0.4	1.0	0.9	2.3
Percent increase	22.3	26.7	23.8	24.7
Federal cost	0.4	0.8	0.6	1.8
Percent increase	26.1	29.6	25.8	27.5
Enrollee cost	---	0.2	0.3	0.5
Percent increase	1.3	19.9	20.6	18.5

Source: Prepared from unpublished data produced by OPM and by the FEHBP Model.

Total FEHBP enrollment could increase by more than 11 percent if the more generous premium-sharing practices typical of the private sector were adopted. An additional 450,000 "potentially insured" Federal workers might elect Self Only coverage if the Government, as employer, paid 100 percent of the premium charges. Adopting private-sector financing practices could therefore cause the FEHBP premiums paid by the Government to rise by $2.5 billion: about $0.6 billion for Federal workers who currently waive FEHBP enrollment, and $1.9 billion more for the 4.0 million Federal workers and annuitants already enrolled.

4. Modifying Current FEHBP Premium Sharing

a. Administration's Proposal. Under current law, calculating the unweighted Big Six formula is the crux of determining the annual Federal contribution. Replacing the unweighted Big Six approach with an enrollment-weighted average of all FEHBP plans, according to the Administration, is an appropriate first step toward better cost control without major structural reform. If applied for illustrative purposes to 1989 premium charges and projected enrollment, the Federal share of premium payments would drop from $8.4 billion to $7.6 billion. But this 9 percent reduction in Federal costs would represent an average enrollee premium increase of 23 percent. As indicated in table 9.4, individuals electing Family coverage would bear about 90 percent of the shift in contributions from the Federal Government to enrollees. Because their current share is relatively small, postal workers electing Family coverage would confront an 84 percent increase.

TABLE 9.4. Effects of Adopting the Administration's Enrollment-Weighted Proposal for Determining Premiums Paid by FEHBP Enrollees in 1989

Enrollees	Self only	Family	Combined effect
Shift in Premium Costs From Government to Enrollees (In millions of dollars)			
Postal workers	10	190	200
Nonpostal workers	20	290	310
Annuitants	50	240	290
Total	80	720	800
Percentage Increase in Enrollee Premiums			
Postal workers	18	84	73
Nonpostal workers	7	25	22
Annuitants	8	22	17
Total	9	29	23

Source: Prepared from data produced by the FEHBP Model.

b. "*Risk Adjusters*". A risk-adjusted approach to setting FEHBP premiums has been advanced by several FEHBP plans. If adopted, total spending for FEHBP premiums need not change. In this case, the per-enrollee premiums for lower-risk enrollees would decrease and those for enrollees who are above-average risks would increase. Thus, the amount of premium payments received by each plan would depend on the risk distribution of its covered population.

As indicated earlier in this chapter, about 90 percent of total FEHBP premiums (estimated for 1989 at $10.4 billion of the $11.6 billion) covers the cost of medical services provided to FEHBP enrollees. This "pure premium" cost averages about $2,600 per FEHBP enrollee. Since this is an average, some enrollees consume less than the $2,600 and some consume more. In general, younger enrollees cost the plans less than older enrollees until Medicare coverage begins. As a group, annuitants without Medicare eligibility are the most expensive enrollees for FEHBP to insure. But regardless of whether a potential enrollee is young, old, sick, or healthy, he or she pays the same premium as anyone else enrolled in a given FEHBP option.

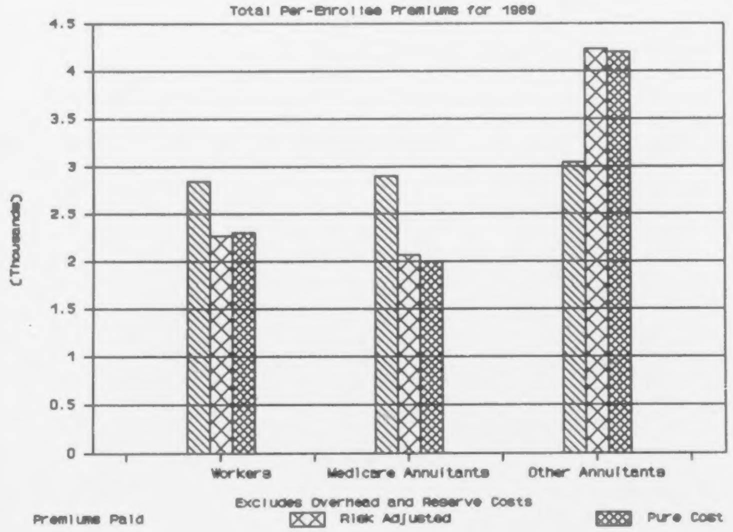
This arrangement produces certain cross-subsidies, which are inherent in any type of insurance plan. FEHBP's cross-subsidies can be quantified by comparing the total premium paid for one or more enrollees, or group of enrollees, against the pure premium cost required to pay for their covered medical services. The premiums paid are relatively easy to compute as is the pure premium for all plans. But given current data limitations, allocating the pure premium cost among groups of enrollees is somewhat subjective. Ideally, it requires collecting the medical service payments made by the plans for each enrollee and for each of the dependents covered by a Family coverage option.

Assuming the data were available, the next step would be to determine how much of the utilization could be explained by the underlying demographic characteristics, which include the age, sex, income, geographic location, and Medicare coverage of each plan's participants. Obviously, for each plan, one could allocate costs very reasonably among alternate demographic groups. The difficulty is to develop a common set of allocation factors that pertains on a systemwide basis.

As one example of a risk-adjusted approach, FEHBP enrollees could be distributed into three categories: Federal workers, annuitants covered by Medicare, and all other annuitants. The results, summarized in figure 9.4, show that annuitants without Medicare coverage are the most expensive group for FEHBP plans to insure and that demographic adjustments can help explain differences in the amount of medical care consumed by certain types of enrollees. They also raise the question of who should finance the higher average costs generated by annuitants without Medicare coverage: the Government, other annuitants, Federal workers, or (as currently done) some combination of the three.

c. *Premiums based on actuarial values*. Private employers that offer a choice among FFS options recognize that risk segmentation does occur. But they have addressed the risk-segmentation problem without using demographic characteristics or other types of risk adjusters. Instead, an actuarial value is determined for each FFS option as though it were the only selection available to the enrollees. The plan with the lowest actuarial value is the base plan. The employer determines how much of the base-plan premium, if any, the enrollee should pay. Enrollees who elect to participate in a plan with a higher actuarial value must pay more. Such additional premiums, however, are limited to the actuarial difference between the base plan and the enrollee's selected option. Thus, the enrollee selects an option on the basis of benefit differences. Additional costs resulting from risk segmentation are financed by the employer. (A more detailed description of this rate-setting alternative is presented in chapter 6, section 6.D.3.)

FIGURE 9.4. FEHBP Premiums Paid in 1989 Compared with Risk-Adjusted and Pure Premium Costs for Workers and for Annuitants with and without Medicare Coverage



APPENDIX A. THE CONGRESSIONAL RESEARCH SERVICE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM COMPUTER MODEL

I. INTRODUCTION

The Federal Employees Health Benefits program (FEHBP) computer model used to estimate health insurance costs and premiums presented in this report was developed by the Congressional Research Service (CRS), in conjunction with Hay/Huggins Company, Inc. (a private actuarial consulting firm). The FEHBP Model is a modified version of the model used by CRS to estimate health insurance premiums for the CRS report, *Costs and Effects of Extending Health Insurance Coverage.*[120]

A. Background

The FEHBP Model is a personal computer (PC) version of a mainframe computer model, the Benefit Valuation Comparison (BVC) Model, developed by Hay/Huggins. The BVC Model, originally developed in 1966, was designed to value employer-provided benefits, including health insurance benefits. The BVC Model has been modified each year to replicate the cost of current employer-based health insurance plans. The updating includes increasing the cost of each provision of the plans and extending the model to include new features being added to health care plans. The model's cost estimates of different provisions are also reviewed annually and validated against national health care cost and utilization norms. The FEHBP Model has been validated against the BVC Model by comparing results of a wide variety of plan features/options run on both models and determining that the obtained results are identical. In addition, a number of features not included in the original BVC Model have been developed for the FEHBP Model.

B. Overview of the FEHBP Model

The FEHBP Model provides the means of estimating health insurance premiums for Federal employees, annuitants, and their families. The model also provides the means of estimating aggregate and plan-specific health insurance costs borne by the Government (employer) and employee/annuitants. Lastly, the model provides estimates of systemwide costs, given specified illustrative redesign options. The model is capable of projecting enrollment and costs, considering the effects of enrollee plan selection. Transfers from an existing plan or program structure to an alternate plan or program structure are modeled.

The FEHBP Model has three major components allowing the analysis of changes in both the nature of the insurance offerings and the population being covered. The first component estimates standard premiums or benefit values for specified health insurance plans. The model uses methods similar to those employed by actuaries and insurance underwriters in estimating premiums necessary to pay for a particular set of benefits offered to a specific population. The model initially estimates premiums for a "standard population" consisting of employees and their dependents who receive private employer-based health insurance.

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[120] U.S. Library of Congress. Congressional Research Service. Committee print prepared for Congress. *Costs and Effects of Extending Health Insurance Coverage*. Oct. 1988.

The second component of the model estimates the value of the current FEHBP. The benefits and features of the current FEHBP are specified, and estimated private sector premiums are adjusted for the demographic characteristics of Federal employees and annuitants. Lastly, the estimated values of FEHBP plans derived from the model are compared to actual FEHBP plan premiums.

The third component of the model estimates and projects systemwide costs under an alternate FEHBP plan/program structure compared to the existing structure. To do this, it projects transfers of eligible enrollees from the existing plan/program structure to an alternate one.

II. STANDARD PREMIUM ESTIMATES

The first component of the model estimates the premium necessary to provide health insurance to a standard (employed private sector) population given a particular set of plan provisions. The model uses the same methodology employed by actuaries and underwriters in developing rate books that insurance companies use to set premiums. Based upon insurance company experience, actuaries have estimated the cost effects of certain variations in plan provisions. For example, raising a plan deductible from $100 to $150 might drop the cost of the premium by $17. Offering "well baby" coverage might increase the premium by $27. Estimates of the effects of health plan provisions on health care costs vary somewhat among insurance companies. The FEHBP Model uses average or blended rate adjusters from several major insurance companies to estimate the effects of plan provisions on premiums, in order to best represent typical rate-setting practices.

The model's health insurance component is composed of the following major sections:

- Hospital costs
- Surgery costs
- Inpatient physician costs
- Outpatient physician costs
- X-ray and laboratory costs
- Inpatient psychiatric costs
- Outpatient psychiatric costs
- Prescription drug costs
- Dental costs
- Vision costs
- Emergency/accident costs

- Extension of coverage to retirees
- Share of premiums paid by employees

The model has been tested against a sample of health plans provided by medium and large employers in the United States.[121] Plan provisions of these employers were specified, and premiums were estimated by the model. Estimated premiums were compared to actual premiums to verify the accuracy of the model.

III. MODELING CURRENT FEHBP

A number of modifications were made to the model in order to analyze the FEHBP. These modifications included specifying existing FEHBP benefits and features and adjusting estimated private sector premiums for Federal demographics. The model results of the estimated values of FEHBP plans were then compared to actual FEHBP premiums.

A. Specification of Existing FEHBP Plans

Nearly 50 FEHBP plans, representing approximately 87 percent of FEHBP enrollees in 1988, have been included in the FEHBP Model for detailed analysis. A list of these plans is shown in table 1. The benefit features and plan provisions offered by each of these plans during the last open season (i.e., 1989 enrollment year) are coded into the model. The plans were selected from groupings of fee-for-service (FFS), health maintenance organization (HMO), and preferred provider organization (PPO) plans on the basis of the size of their enrolled populations, premium levels (high, medium, and low), and geographic representation.

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[121] The sample consists of nearly 900 medium to large industrial, financial, and service employers included in the Hay/Huggins Benefits Survey (HHBS). This data base covers approximately 25 million people who receive health insurance benefits through these employers.

TABLE 1. FEHBP Plans Selected for Detailed Study

Blue Cross/Blue Shield High
Blue Cross/Blue Shield Standard
Aetna High
Aetna Standard
AFGE (American Federation of Government Employees) High
AFGE Standard
GEHA (Government Employees Hospital Association)
NALC (National Association of Letter Carriers)
Postmasters High
Postmasters Standard
Rural Letter Carriers
Foreign Service
Panama Canal Area
SAMBA (Special Agents Mutual Benefit Association)
Mail Handlers High
Mail Handlers Standard
Alliance High
Alliance Standard
APWU (American Postal Workers Union)
GHA (Group Health Association, Washington, D.C.) High
GHA Standard
HIP/HMO (Health Insurance Plan)
NFFE (National Federation of Federal Employees) High
NFFE Standard
Postal Supervisors
NTEU (National Treasury Employees Union)
GEBA (Government Employees Benefit Association)
BACE (Beneficial Association of Capitol Employees)
SSEHA (Secret Service Employees Health Association)
Group Health, Inc. High (Twin Cities)
Kaiser (Northern California)
Kaiser (Southern California)
Kaiser Hawaii High
Michael Reese
GHI (Group Health Incorporated, New York)
Washington Physicians Service (Washington)
HMSA (Hawaii)
SSS Plan (Puerto Rico)
Foundation
HMO Florida
Kaiser Mid Atlantic
M.D.-IPA
HMO New Jersey High
HMO of Pennsylvania High
Health America Texas
NAGE (National Association of Government Employees) High
NAGE Standard
NAPUS (National Association of Postmasters of the United States)

B. Creation of "Typical" Private Sector and FEHBP Plans

For purposes of comparing private sector and FEHBP practice, CRS and Hay/Huggins developed hypothetical, or composite, FFS health plans representing "typical" private sector and FEHBP practice. In developing these plans, CRS and Hay/Huggins identified the most prevalent benefit provisions found in health plans offered by medium and large firms and those offered under FEHBP.

The "typical" private sector plan incorporates benefit features most commonly found among medium and large firms and is based primarily on data in the 1988 *Hay/Huggins Benefit Report (HHBR).* In addition, data from the *HHBR* was supplemented by information from the Bureau of Labor Statistics' 1986 *Survey of Employee Benefits in Medium and Large Firms.* The "typical" FEHBP plan incorporates the most prevalent benefit features of FFS plans available to FEHBP enrollees during the last FEHBP open season. It should be emphasized that these "typical" plans are composite plans incorporating the most common plan features and that the combination of these features may not produce a plan as found in actual practice.

As previously mentioned, the typical plans were developed to compare FFS plans in FEHBP and the private sector. Typical HMO plans were not developed for two reasons. First, although HMOs have become more widespread, fewer than one-fourth of FEHBP enrollees and one-fifth of employees in medium and large firms are in such plans. Second, there is more variation among FFS plans than among HMOs, since HMOs generally offer comprehensive benefits.

C. Adjustments for FEHBP Provisions

The model has been adapted to take into account a number of plan features that are not typically provided in the private sector (e.g., no pre-existing condition limitations), as well as plan features that are provided in the private sector but not allowed in FEHBP (e.g., abortion).

D. Adjustments for Federal Demographic Characteristics

The cost and use of medical and hospital services tend to vary according to the demographic characteristics of the population. For example, younger persons, as a group, cost less to insure than older persons. Similarly, younger women generally cost more to insure than younger men because of the costs associated with childbearing. Persons with lower incomes faced with the same deductible and coinsurance limits as those with higher incomes tend to use health care less than persons with higher incomes. Lower-income persons also tend generally to live in areas with lower-priced health care and tend to use less expensive health care providers than persons with higher incomes. On the other hand, there is some evidence that lower-income persons may have poorer health than higher-income persons.

The model initially provides estimates of the premium costs (benefit values) of the plans as if they were offered to the nonfederal workforce. The model's cost estimates may initially differ from the actual costs for a specific employer (i.e., the Federal Government) because of demographic, economic and financial factors that apply to the individual employers. Consequently, estimated premiums from the model are then adjusted to reflect demographic differences between the standard population profile used by the model and the population profile of the Federal workforce and annuitants enrolled in FEHBP.

Estimated premiums from the model are adjusted for the demographic characteristics of FEHBP enrollees. The adjustment factors used are based on actuarial studies of how health care costs vary by characteristics of the population. Adjustments are made on the basis of the characteristics of the population according to its age and sex composition, income, annuitant status, Medicare/nonmedicare status, and geographic (State, rural/urban) location. Adjustment factors were applied to the Federal population using demographic data files of Federal workers and annuitants supplied by the Office of Personnel Management (OPM). The data files contain information on over 5 million Federal workers and annuitants, including: age, sex, income, geographic location, type of worker (i.e., postal, nonpostal), type of annuitant (i.e., Medicare, nonmedicare, spouse or child survivor), and FEHBP status (i.e., plan in which enrolled, waived coverage, ineligible) in 1987 and 1988. Individual identification numbers were scrambled by OPM to ensure confidentiality. A demographic adjustment factor was calculated for each person represented on the data file according to each person's characteristics and the specific adjustment factors associated with each characteristic.

1. *Standard Federal Population Demographic Characteristics*

The enrolled FEHBP population is referred to throughout this report as the standard Federal population (SFP). Demographic adjustment factors were calculated, based on the SFP, in order to determine how health plan premiums for the Federal Government differ from those of private sector plans as a result of differing characteristics of their enrolled populations.

As a result of the demographic adjustments applied to the SFP, health insurance premiums for FEHBP enrollees are estimated to be about 20 percent higher than they would be if the same plan were offered to health plan enrollees of medium to large private firms. The difference in premiums may be attributed to differences in the characteristics of current Federal employees and private sector workers and the inclusion of annuitants in FEHBP.

a. Current Employees. Overall, the demographic characteristics of current Federal employees tend to make them slightly more costly to insure than employees in medium to large private sector firms. Based on their characteristics (age, sex, income, geographic location), the average premium for the FEHBP population is about 3 percent higher than it would be if the same plans were offered to a private sector population.

b. Annuitants. The inclusion of annuitants in FEHBP results in higher average premiums than if FEHBP were offered only to current Federal employees. Because they are older and consequently greater users of health care services, annuitants generally have higher medical costs than current employees. However, their cost to FEHBP in large part depends upon whether or not they are covered by Medicare.

The cost of insuring annuitants who are age 65 and older is less for those with Medicare coverage than for those without Medicare coverage, since Medicare is the primary payer of claims.[122] In fact, because of Medicare, the costs of insuring annuitants borne by a health plan may actually be less than the costs of insuring current employees.

The cost of insuring FEHBP annuitants is greater than the cost of insuring their private sector counterparts largely due to differences in the incidence of Medicare coverage between the two groups. Nearly all annuitants age 65 and older receiving private employer-provided health benefits are covered by Medicare. In contrast, about three-quarters of FEHBP annuitant enrollees age 65 or older are covered by Medicare. The demographic adjustment for FEHBP annuitants results in health plan premiums that, overall, are an estimated 43 percent higher than what would be expected based on private sector demographics of employees in medium to large firms. The demographic adjustment for Medicare annuitants results in estimated average premiums that are 6 percent *lower* than premiums based on the standard private sector population. However, adjustments for nonmedicare annuitants result in estimated average premiums that are 94 percent *higher*.

TABLE 2. Effect of Demographic Adjustments on Estimated FEHBP Premiums, 1988

	Overall weighted adjustment	Percent of FEHBP enrollees
Private sector population	1.00	---
Total (standard Federal population)	1.20	100.0
Current employees	1.03	59.2
Annuitants	1.43	40.8
Medicare covered	0.94	20.8
Nonmedicare covered	1.94	20.0

Source: FEHBP Model.

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[122] See chapter 7 of this report for a discussion of issues relating to the provision of health insurance to the Federal annuitant population.

2. *Plan Specific Demographics*

Adjustments to estimated premiums for plans' specific demographics provide some indication of the effects of favorable or adverse selection on costs among plans. Some plans under FEHBP have demographic profiles that are considerably more favorable (i.e., result in lower health care costs) than the SFP demographics; other plans have considerably less favorable demographic profiles. For example, the demographic adjustment for SAMBA Family coverage is about 28 percent lower than that of the SFP. The demographic adjustment for Aetna Family High Option is about 27 percent higher than the SFP adjustment.

E. Other Factors Affecting Health Plan Premiums

The model provides estimates of what an insurance carrier could reasonably expect a health benefit package to cost if offered for the first time to the eligible Federal population. Estimated premiums from the model may differ somewhat from the actual premiums charged or the actual costs borne by a specific plan, however. In the model, demographics are used as proxies for health care utilization. While health care costs vary according to demographic characteristics, demographics alone account for only part of the variability in costs and premiums.

A variety of factors other than plan demographics may contribute to the difference between the model's estimated premiums and actual FEHBP plan premiums. The factors include: administrative expenses, reserve policies, additional health care use by the population not captured by demographics, the plan's reputation among the eligible population for providing service and value, and differences in the FEHBP Model's and individual carriers' rate-setting procedures.

1. *Administrative Expenses*

Part of FEHBP premiums are used to pay program administrative expenses rather than to pay health care costs.[123] The FEHBP Model takes these expenses into account.

a. Carrier's net premiums. A part of the total FEHBP premium for each FEHBP plan (1 percent) is allotted to OPM for administering the program. An additional 3 percent of the premium is allotted to a contingency reserve fund. Total premiums less the OPM administrative percentage and 3 percent premium contingency reserve are referred to throughout the report as net-to-carrier (NTC) premiums.

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[123] See chapter 9 of this report, *Costs and Financing for the Federal Employees Health Benefits Program*, for a discussion of administrative costs and the "anatomy of a premium."

b. "Pure" premiums. Part of premium costs are allotted to individual carriers to administer the program. These administrative costs include paying staff and overhead, State premium taxes, and carrier profits. FEHBP administrative expenditures in 1989 under the FEHBP plans selected for detailed study range from just under 4 percent to above 11 percent of premium costs. Plan administrative expenditures can be subtracted from carrier's net premiums to arrive at estimates of premium costs used solely for paying health care claims. These costs are referred to as "pure" premium costs throughout the report.

2. *Plan Reserves*

Estimated premiums from the model may differ from actual FEHBP premiums as a result of plan reserves.[124] Estimated premiums from the model may be somewhat lower than a plan's actual premiums if the plan's reserves are accumulating (i.e., total premiums exceed total claims paid during a year). Similarly, estimated premiums may be somewhat higher than a plan's actual premiums if the plan's reserves are diminishing (total claims exceed total premiums during the year). The model makes no explicit adjustment to estimated or actual premiums to account for changing reserve levels. It assumes that reserves as a percentage of total program cost remain unchanged. In practice, however, individual plans' reserves are likely to fluctuate from year to year, as plans either over- or underestimate their costs (i.e., claims) relative to premiums. In any given year, the model may under- or overestimate a specific plan's actual premiums, in part due to the fact that the actual plan premium may reflect the plan's efforts to adjust reserves.

3. *Health Care Utilization*

The FEHBP eligible population varies widely. Demographic adjustments do not fully account for differences in the use of health care in a population--there are healthy as well as unhealthy annuitants, for example. The premium charged and costs borne by a particular plan depend in large part on the segment of the eligible population that actually selects the plan. FEHBP offers the eligible population substantial choice among plans.[125] The degree to which a plan experiences "adverse" or "favorable" selection by the eligible population can greatly affect the premiums and costs of the plan. A plan that attracts healthy, or low utilizing, segments of the population may be able to offer lower premiums and better maintain its market position than a plan that attracts the unhealthy, or high utilizing, segments of the population. Some, if not most, of the difference between the estimated value and actual premium across plans may be due to differences in the use of health care across plans that is not captured by demographics.

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[124] See chapter 9 of this report, *Costs and Financing for the Federal Employees Health Benefits Program*, for a complete discussion of reserves in FEHBP.

[125] See chapter 6 on *The Issue of Choice*.

4. Plan Reputation of Value and/or Quality of Service

The estimated premiums derived from the model may differ from the actual premiums charged because of differences in the eligible population's perception of a plan's value which cannot be modeled explicitly. Some plans make substantial marketing efforts during the open season to promote the plan's name and features. In addition, favorable or unfavorable impressions of plan service or value, based on enrollee experience, may spread quickly by word-of-mouth among the Federal population. Favorable name recognition of a particular plan may allow it to charge a premium that is higher than the estimated value obtained by modeling its provisions alone. Favorable or unfavorable plan name recognition may result from impressions of service or quality that are not explicitly treated by the model.

Plans that otherwise appear equal may differ qualitatively in terms of their administration or level of service. For example, the method and timeliness of claims payment may differ from plan to plan. Plans that more frequently deny or delay payment, have longer queues for service, have a greater share of claims under adjudication, or have seemingly complicated claims filing procedures, may have premiums that are lower than plans that do not, even though they otherwise appear equal. While such measures may reduce overall plan expenditures by helping to control costs and perhaps utilization, the additional "hassle" that such measures represent to the enrollee reflects a price not captured by the model. Such measures may also drive away the claims filers (i.e., "unhealthy"), while retaining those who do not file claims (i.e., "healthy").

5. Modeling Differences

Part of the difference in the estimated value of a particular plan and the actual premium charged may be due to differences in the rate-setting procedures used by the model and the particular plan. As mentioned earlier, the FEHBP Model uses average or blended rates to estimate the effects of plan provisions on premiums. These rates may differ somewhat from the rates used by a particular carrier to establish premiums. The FEHBP Model uses "generic" rates, rates deemed reasonable if a plan were offered for the first time by a carrier. Actual premiums set by a carrier reflect the carrier's own rates, based both on common practice and the particular experience of its covered population. Actual premiums reflect not only the carrier's own estimates of the cost of individual plan features, but also its estimates of utilization, change in reserves, and its ability to control costs through administrative procedures.

IV. MODELING ALTERNATIVES TO THE CURRENT SYSTEM

Illustrative alternatives to the current FEHBP may be specified, and their effects modeled, using the FEHBP Model. The model estimates benefit values for plans in both the current and alternative structures.

A. Specifying Alternatives

The model allows the user to specify an alternative health insurance plan/program structure to the current FEHBP. A number of standard features can be specified, such as estimating the costs for annuitants under a separate program; specification of the Government's cost-sharing formula (e.g., simple average Big Six plans, weighted average of all plans), assumptions about HMO growth, as well as specific details about plan benefits and features offered under the illustrative alternative. The model can provide estimates of aggregate Government and enrollee costs under the plan.

The model allows for the direct specification of over 200 detailed plan provisions that may be altered. These plan benefits and features may be readily included or excluded from any particular plan. A variety of plan provisions and features, not specifically related to any particular plan, are included in the model, expanding both the scope and detail of plan benefits/features that can be modeled as illustrative plan alternatives. These additional features allow for a refined tailoring of benefits and inclusion of benefits that, while uncommon, are offered by some plans (e.g., vision care). For example, the model allows for a "generic" dental plan to be included, either as part of the main health insurance plan or as a separate plan. Detailed provisions of the generic plan may be easily altered (e.g., to include orthodontics). This design allows for ease of specification when changing the most common aspects of a health insurance plan. At the same time, almost any combination of health plan provisions can be analyzed by altering the underlying detailed provisions in the model.

B. Estimating Aggregate Government and Enrollee Costs--Static and Dynamic Cost Estimates

The model provides both static and dynamic cost estimates. Because static cost estimates are of limited value, only dynamic cost estimates are presented in this report.

1. Static Cost Estimates

A static cost estimate provides one benchmark, albeit limited, for comparing the cost of illustrative plan structures to the current system. The static cost estimates derived from the model are simply based on the estimated value of the alternative plan structure, adjusted for SFP demographics. This approach is limited, since it does not take into account the manner in which the eligible FEHBP population might be expected to transfer from one plan to another or to opt in or out of FEHBP coverage altogether.

2. Dynamic Cost Estimates

The dynamic cost estimate provided by the model apportions the existing FEHBP enrollment and associated expenses to the illustrative plan/system alternative through the use of a "transfer model." The model also takes into account the effect on costs of persons who, while having opted out of the current system, might join an alternative system.

a. Transfer model. The transfer model is based on the relationship between enrollees' estimated health care costs and plan premiums. The transfer model assumes that enrollees behave rationally by enrolling in plans that minimize out-of-pocket costs. The model also acknowledges that enrollees do not have perfect knowledge about the health care costs they may incur in any given year, nor complete knowledge about the plan benefits and features from which they can choose. Enrollees also differ in their tendencies to expose themselves to the risk of incurring high out-of-pocket claims. Faced with the choice of a new plan structure, enrollees might be expected to select plans that would minimize their out-of-pocket costs given their existing level of utilization. At the same time, they might also be expected to seek out plans that are most like the one in which they are already enrolled. The transfer model considers both of these extremes, identifying an "inertia plan" (i.e., the plan most like the one in which currently enrolled) and a "movement plan" (i.e., the plan that would minimize out-of-pocket expenses at the current level of health care utilization).

In order to model the transfer process, a distribution of health care expenses incurred by enrollees of FEHBP plans had to be specified. The FEHBP Model only provides estimates of the *average* plan value, or estimated premium, that characterizes the plan's features and its group of enrollees. The transfer component of the model depends on an assumed distribution of claims within plans, however.

Separate "generic" distributions of claims by claims category were defined for Self Only and Family coverage and for high and low option plans. The distributions were based on an analysis of OPM "utilization reports" for a number of FEHBP plans. These reports provide detailed distributions of health care claims by type of enrollee. The generic claims distributions used by the model are defined by five claim categories: (1) negligible claims (less than $100); (2) minor claims ($100 to $500); (3) severe spell of illness ($500 to $1,000); (4) one hospitalization ($1,000 to $10,000); and (5) major expenses (greater than $10,000). The generic distributions are defined by the estimated average claim within each claim category and the estimated percent of claims occuring in each category. The generic claims distributions are adjusted for each plan so that the sum of estimated claims incurred, by claims category, equals the aggregate premiums for the plan. The generic claims distributions were then modified for each plan by applying each plan's deductible and coinsurance provisions in order to obtain a distribution of enrollee health care expenses.

"Movement plans" under the alternative plan/program structure are identified for enrollees in each expense category under the existing FEHBP structure. A movement plan is a plan that, given its estimated premium, deductible and coinsurance provisions, would minimize out-of-pocket costs of enrollees in each expense category.

The model assumes that the tendency of enrollees to transfer to the movement plan is likely to be greatest for those who could reduce their out-of-pocket costs the most by doing so. Transfer rates were derived from an analysis of OPM data of persons switching FEHBP plans between 1987 and 1988. Transfer rates were derived by evaluating the claims in each expense category, relative to the premiums, deductibles, and coinsurance of the plan in which persons were enrolled in 1987 and 1988. Based on this analysis, the following assumptions were derived. If the estimated out-of-pocket cost could be reduced by $50 or less by transferring from the inertia to the movement plan, a 2 percent transfer rate from the inertia to the movement plan was assumed. For reductions of out-of-pocket costs from between $50 and $100, the transfer rate ranges from 2 to 10 percent. For reductions in out-of-pocket costs of between $100 and $300, the transfer rate was assumed to range from 10 to 20 percent; for reductions in out-of-pocket costs in excess of $300, the transfer rate was assumed to be 20 percent.

b. Enrollees in HMOs. The transfer process for enrollees in HMO plans is treated separately from the transfer process described above. HMO enrollees had to be treated separately from enrollees in FFS plans because of the lack of data on enrollee residence relative to HMO service areas, and the lack of health care expense distribution data for HMO enrollees. HMO enrollment is assumed to grow by 5 percent per year, subject to the availability of HMOs under each illustrative plan/program alternative.

c. Cost summary. Total program, Government, and enrollee costs are tallied after having specified the illustrative plan/program structure and modeled the transfer process. Costs are adjusted for increases in overall health care prices, and adjustments are made for changes in the size of the eligible Federal population covered by the program.

APPENDIX B. ORIGINS AND CURRENT STATUS OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

I. WHY FEHBP WAS CREATED

In 1959, the Federal Government as a whole did not provide health benefits to its civilian employees or retirees. Although some Federal agencies and employee organizations offered group health plans to their employees or members,[126] the vast majority of Federal employees had to find their own source of group medical protection or find and purchase health care coverage on an individual subscription basis. Health benefits coverage was already available to 123 million nonfederal employees, retirees, and their dependents, more than 75 percent of whom were enrolled through their places of employment.[127] Between 1947 and 1959, recognition of this disparity led to the introduction of at least 30 bills proposing to establish a Federal health benefits program. Disagreements among employee groups, carriers, and proponents of the bills, however, prevented any measure from coming out of committee in either the House or the Senate until 1959.

The urgent need for a joint Government-employee health benefits program was recognized by both the House and the Senate in their consideration of S. 2162, the bill which established a health benefits program for the Federal workforce. The House Committee on Post Office and Civil Service noted that "enlightened, progressive, private enterprise almost universally has been establishing and operating contributory health benefit programs for its employees" and that the Federal Government has made "scant progress in this area."[128] The Senate Committee on Post Office and Civil Service noted ". . . clear evidence of the recognition of private employers that participation with their employees in obtaining health insurance contributes to the well-being and efficiency of their workers." The Senate committee also observed that "the desire for such an arrangement was evident from the fact that Federal employees had developed various kinds of quasi-groups [for the purpose of purchasing health benefits at group rates] on their own initiative."[129]

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[126] The Federal Bureau of Investigation, the National Security Agency, the Central Intelligence Agency, and the Foreign Service were among the Federal agencies sponsoring health benefit plans for their employees.

[127] U.S. Congress. Senate. Committee on Post Office and Civil Service. *Federal Employees Health Benefits Act of 1959*. Report to Accompany S. 2162. Senate Report No. 86-468, 86th Cong., 1st Sess. Washington, U.S. Govt. Print. Off., 1959. 31 p.

[128] U.S. Congress. House. Committee on Post Office and Civil Service. *Government Employees Health Benefits Program*. Report to Accompany S. 2162. House Report No. 86-957, 86th Cong., 1st Sess. Washington, U.S. Govt. Print. Off., 1959. 22 p.

[129] Senate Report No. 86-468, p. 1.

II. OVERVIEW

The FEHBP is a jointly financed Government-employee program providing voluntary health insurance coverage to Federal employees and annuitants (i.e., retirees) and their dependents. Its purpose is to provide "full or substantially full protection against expenses of both common and catastrophic illness or injury."[130] The program is authorized by the Federal Employees Health Benefits Act of 1959 (P.L. 86-382) and went into operation on July 1, 1960. FEHBP was created to eliminate the benefits disparity between the Federal Government and private employers as well as to help attract and retain competent personnel. In 1989, FEHBP covers approximately 9 million enrollees and their dependents at a total annual cost to the Federal Government and to enrollees of approximately $11.6 billion.

This overview covers the following major aspects of the program:

- **Eligibility**--The program covers most Federal employees and annuitants and their dependents with certain exclusions.

- **Types of plans**--There are three types of plans in FEHBP: (1) Government-wide plans, including a Service Benefit Plan (offered by Blue Cross/Blue Shield) and an Indemnity Benefit Plan (offered by the Aetna Life Insurance Company); (2) Employee Organization Plans (sponsored by employee organizations); and (3) Comprehensive Medical Plans, also known as health maintenance organizations (HMOs), which are prepaid health plans that provide care using designated physicians and hospitals.

- **Enrollment**--Employees voluntarily decide whether or not they wish to participate in the program. There are two types of enrollments, Self Only, which covers the individual employee, and Self and Family, which covers the employee and his or her dependents. There is an open enrollment period prescribed by OPM regulations when an eligible employee may enroll in a plan, or may change plans, options, and type of enrollment.

- **Termination of enrollment, temporary extension of coverage, and conversion**--In general, enrollment in FEHBP ceases when an employee leaves Federal employment for reasons other than retirement. However, coverage under a FEHBP plan may continue temporarily after such termination. After the temporary extension ends, the employee may exercise the option of converting to a nongroup health benefits contract, paying the associated charges in full.

- **Benefits**--Most FEHBP plans cover the costs of inpatient care (including room and board charges, and surgeons and other doctors' fees), outpatient care, (including coverage for physician charges, diagnostic tests, and accidental injuries), and some degree of coverage for catastrophic events. Some plans also cover dental care, prescription drugs, home health care, etc. In addition, several plans offer two levels of benefits: a standard option with more limited coverage, and a high option with more extensive coverage.

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[130] House Report No. 86-957, p. 3.

- **Financing**--Premiums to pay for the benefits provided by FEHBP are paid jointly by the Federal Government and the employee or annuitant. On the average, the Government pays approximately 70 percent and the employee or annuitant pays approximately 30 percent of the premium cost.
- **Administration of the program**--FEHBP is administered by the Office of Personnel Management (OPM), which performs such activities as negotiating yearly with plans to determine benefits and premiums for the following year, managing FEHBP premium payments, approving qualified plans for participation in the program, and determining the times and conditions under which the open enrollment period will take place.[131]

III. ELIGIBILITY

FEHBP covers Federal employees, annuitants, and their dependents. Enrollment is voluntary and may be ended by the enrollee at any time. An employee is defined as an individual who is appointed or elected to a position in the executive, legislative, or judicial branch of the U.S. Government, including Government owned or controlled corporations, the Government of the District of Columbia, and Gallaudet College.

FEHBP covers permanent employees with regularly scheduled tours of duty. The Federal Employees Health Benefits Amendments Act of 1988 (P.L. 100-654) provided coverage effective March 14, 1989, for temporary employees who have completed 1 year of current continuous employment; they are required to pay the total premium, including the Government share. The Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615) added coverage for certain former spouses of employees (and of former employees and annuitants); they are also required to pay the total premium amount.

Certain annuitants (retirees) and survivor annuitants (members of the family of a deceased employee or annuitant) also are covered by FEHBP. They pay the same premiums and receive the same benefits[132] as active employees enrolled in the same plan. When the original FEHBP legislation was enacted in 1959, only annuitants who retired on or *after* July 1, 1960 and their dependents were covered.[133] One year later, the Retired Federal Employees Health Benefits Act of 1960 (P.L. 86-724) created a separate health program, similar to the already existing FEHBP for employees who retired or became disabled *before* July 1, 1960. In 1974, P.L. 93-246 permitted annuitants participating or eligible to participate in the *retired* FEHBP and their family members to participate in the *regular* FEHBP established in 1959 by P.L. 86-382.

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[131] See title 5, U.S.C., chapter 89, sections 8901-8913 and 5 CFR chapter 1, Part 890 for more detailed information.

[132] FEHBP plans are required to waive their deductible and coinsurance amounts for FEHBP annuitants who also have Medicare coverage.

An employee is eligible to continue enrollment into retirement if: (1) the employee retired under a retirement system for civilian employees of the Government (Federal or District of Columbia); (2) the retirement is on an immediate annuity (one which begins within 1 month after the separation date); and (3) the employee was enrolled or covered as a family member in FEHBP for the 5 years of service immediately preceding retirement or for all service since the first opportunity to enroll in FEHBP. Survivor annuitants who were covered under a family enrollment may continue their coverage after the death of the employee or annuitant.

IV. TYPES OF PLANS

When the FEHBP legislation was being considered, the House and Senate committees were aware of the tremendous leverage the Federal Government, as the Nation's largest employer, could exercise to encourage and obtain "sound" health service and financing arrangements.[134] Committee members wanted the Federal program to encourage a variety of health plans and to offer participants a variety of plan choices and freedom to select the plan best suited to their needs. The Senate committee report, however, noted that while reasonable competition among different plans would make for a better program, unrestricted competition could make FEHBP "unwieldy and ineffective."[135]

FEHBP is unusual when compared to health care coverage provided in private industry, in that the FEHBP enrollee has a broader choice among health plans with varying levels of benefits and premiums. The FEHBP statute prescribes, in general, the three major types of plans which OPM may contract for or approve. The types of plans are as follows:

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[133] Ways of including annuitants in FEHBP who retired or became disabled *prior* to July 1, 1960 were explored in great detail. However, due to cost considerations and because the Eisenhower Administration was opposed to providing coverage for this group, action was deferred. Effective July 1, 1961, P.L. 86-724, the Retired Federal Employees Health Benefits Act of 1960, authorized a health benefits program for Federal annuitants and their families who retired or became disabled *prior* to July 1, 1960.

[134] Senate Report No. 86-468, p. 4.

[135] Senate Report No. 86-468, p. 4.

A. Government-Wide Plans

- ***The Service Benefit Plan***, a Government-wide plan with high and standard options available to all employees, sponsored and administered by the National Blue Cross and Blue Shield Association through local Blue Cross/Blue Shield affiliates, providing benefits generally through direct payment to doctors and hospitals, and
- ***The Indemnity Benefit Plan***, a Government-wide plan with high and standard options available to all employees, sponsored by the commercial insurance industry and administered by the Aetna Life Insurance Company, providing benefits by cash reimbursement to the employee or through direct payment to doctors and hospitals.

The authors of the FEHBP legislation intended that the Federal health program offer benefits comparable to those offered in the private sector. The Service Benefit and Indemnity Benefit plans were therefore included in FEHBP because these types of plans were already widely accepted by the public generally and by Federal employees in particular.[136] The House and Senate committees expected that for most eligible participants, the choice would be between these two types of plans.[137]

B. Employee Organization Plans

These are plans sponsored by employee organizations and are available only to employees who are, or who become, members of the sponsoring organization. When the original legislation was being considered, witnesses from employee organizations which were then sponsoring health insurance plans testified in support of their inclusion in FEHBP, saying that they would not be able to continue operation if excluded from the program, and that former employees and retired persons remaining in an excluded program would suffer.[138] The authorizing FEHBP legislation specified that employees would be able to enroll in employee organization plans *only* if they were members of the organization at the time of enrollment. Some employee organizations plans are open to all Federal employees who join the organization, while others are open only to certain groups of employees. Normally a membership fee is charged, in addition to the health plan premium. Such plans provide benefits generally by cash reimbursement to the employee or, upon request, by direct payment to doctors and hospitals. There are 20 such plans, with a total of 26 options, in the program in 1989.

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[136] Data presented during hearings on S. 2162, for example, showed that BC/BS plans already covered approximately 1 million Federal employees and their dependents.

[137] Indeed, the Service Benefit and the Indemnity Benefit plans enrolled about 80 percent of the total FEHBP enrollment for the first decade of the program's operation. Source: Towers, Perrin, Forster and Crosby, Inc. *Study of the Federal Employees Health Benefits Program*. Washington, 1988. p. 29.

[138] Senate Report No. 86-468, p. 9.

C. Comprehensive Medical Plans

These plans, more commonly known as health maintenance organizations or HMOs, are available only to employees and annuitants living in certain geographic areas, and unlike traditional insurance plans, they combine the delivery and financing of health care into a *single* system, providing comprehensive medical services for a prepaid premium amount. Witnesses representing prepaid health plans at FEHBP authorization hearings impressed the House and Senate committees with the scope of the benefits they offered to their enrollees. In particular, the value of the preventive and diagnostic services they provide and the reduction in the use of hospitals due to increased use of outpatient facilities were noted by the House and Senate committees.[139]

There are currently three kinds of comprehensive health plans: **group practice plans**, where services are provided by the plan's doctors at the plan's medical offices or hospitals within the area served by the plan; **individual practice plans**, where the plan makes agreements with local doctors and area hospitals to provide services to its members and generally makes direct payments to these providers of services; and **mixed-model plans**, which are a hybrid containing elements of the group and individual practice plans. There are approximately 420 such plans in the program in 1989.

There are about 450 FEHBP plan options in 1989 compared to 55 in 1961, the first full year of FEHBP operation. However, as discussed earlier, not all plans are available to all employees or annuitants. In 1989, the least number of choices available to any employee is 21, the most 37, with the difference largely attributable to the number of HMOs in the enrollee's geographic area. Currently, HMOs are the only types of plans that can still enter the program. The authorizing legislation provides for only one Service Benefit Plan and one Indemnity Benefit Plan, both of which have operated within the program since its inception. New employee organization plans have been precluded from joining the program since January 1, 1964, except for two "windows," from December 31, 1978 to January 1, 1980 (authorized by P.L. 95-368) and one for the 90-day period following June 17, 1985 (P.L. 99-53).

V. ENROLLMENT

Within 31 days after becoming eligible to participate in FEHBP, employees must decide whether or not they wish to enroll. Each plan participating in FEHBP offers two types of enrollments, Self Only (which provides benefits only for the employee) and Family (which provides benefits for the employee and eligible family members). Eligible family members include: spouse; unmarried children under age 22, including adopted children and recognized natural (illegitimate) children; dependent stepchildren and foster children who live with the employee in a regular parent-child relationship; and any unmarried children over age 22 who are incapable of self support because of a mental or physical disability which existed before age 22. Under a Family enrollment, dependents are eligible for the same benefits as employees.

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[139] Ibid.

Under specified circumstances, employees are allowed to change their coverage or to change a decision not to enroll (for example, if there are certain changes in marital or family status). In addition, there is an open enrollment period commonly called the "open season," when eligible employees may enroll in plans, and employees and annuitants already enrolled may change plans, options, or type of enrollment. Regulations issued by OPM in 1982 indicated that open seasons would be held annually, beginning in November and concluding in December, unless otherwise announced by OPM. The Federal Employees Benefits Improvement Act of 1986 (P.L. 99-251) required that OPM provide a 3-week open season before the start of any contract year in which there are adjustments in rates or benefits, a new plan is offered or an existing plan is terminated.

VI. TERMINATION OF ENROLLMENT, TEMPORARY EXTENSION OF COVERAGE, AND CONVERSION

An employee or an annuitant may voluntarily cancel enrollment at any time. Currently, coverage of an enrollee and his or her dependents continues temporarily for 31 days after the enrollment terminates for any reason except voluntary cancellation. If the employee is confined in a hospital on the 31st day of the temporary extension of coverage, benefits continue during continuous confinement up to a maximum of 60 more days. These temporary extensions of coverage, which are without premium cost to the employee, end on the effective date of a new enrollment or conversion to a nongroup contract.

If an enrollment ends for any reason *other* than voluntary cancellation, or if the coverage of a family member ends for any reason except when an employee cancels enrollment or changes to a Self Only enrollment (e.g., upon divorce or a child's attainment of age 22), the person whose enrollment or coverage is ended has the right to convert to a nongroup health benefits contract offered by the FEHBP plan in which the person was enrolled. The individual does not have to submit evidence of insurability (i.e., evidence of good health) in order to convert. Many FEHBP plans provide fewer benefits under their converted nongroup contracts than under FEHBP, at generally higher premium rates. The Government does not contribute toward the cost of a nongroup conversion contract.

The Federal Employees Health Benefits Amendments Act of 1988 (P.L. 100-654) required, effective for the 1990 contract year, temporary continuation of FEHBP coverage for employees separated from service (coverage for 18 months) and for individuals no longer meeting unmarried dependent child requirements (coverage for 36 months) with such employees and individuals paying the full premium amount.

VII. BENEFITS

Some of the plans participating in FEHBP offer two levels of benefits, a high and a standard option. This feature was incorporated into FEHBP's design to aid lower-income employees and annuitants. The **standard option** provides more limited benefits (usually with greater patient cost-sharing) at a lower premium, while the **high option** offers more comprehensive coverage and costs more. By law, the two Government-wide plans (BC/BS and Aetna) must offer two levels of benefits. In addition, 8 employee organization plans and 34 comprehensive medical plans (HMOs) offer two levels of benefits. All plans must provide coverage for both Self Only (benefits only for the employee or annuitant) and for family (benefits for the employee or annuitant and for eligible family members).

The authorizing FEHBP legislation specified that certain basic health benefits were to be offered by plans participating in FEHBP, based on the "usual pattern" of benefits then available to most people. The FEHBP statute indicates that the various types of FEHBP plans *may* offer the following benefits:

a. **Service benefit plan**--hospital benefits, surgical benefits, inhospital medical benefits, ambulatory patient benefits, supplemental benefits, and obstetrical benefits.

b. **Indemnity benefit plan**--hospital care, surgical care and treatment, medical care and treatment, obstetrical benefits, prescribed drugs, medicines and prosthetic devices, and other medical supplies and services.

c. **Employee organization plans and comprehensive medical plans**--benefits of the types under a. or b. (above) or both.

The law also specifies that the two Government-wide plans must include benefits for "costs associated with care in a general hospital and for other health services of a catastrophic nature."

Although the aforementioned benefits were specified in P.L. 86-382, latitude to adopt alternative types of benefits was also provided in the legislation. In addition, although no minimum or maximum level of benefits was prescribed, OPM was authorized to promulgate regulations and set minimum standards for health benefits plans, consistent with the authorizing committees' desire that FEHBP provide health benefits that would encourage prevention and discourage the unnecessary use of expensive medical facilities and services.

The OPM contracts annually with each of the FEHBP plans, with the contract specifying each plan's benefit structure and premium rate for the next plan year. The authorizing statute specifies that each contract shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as OPM considers necessary or desirable.

All plans provide hospital care on both an inpatient and outpatient basis, medical and surgical care both in and out of the hospital, emergency care, and maternity care. Many plans provide supplemental benefits for doctors' services, prescription drugs, private nursing, renal dialysis, medical appliances, and other medically necessary services and supplies. Each includes some degree of catastrophic protection (a limit on the amount the employee or annuitant must pay in a calendar year if large medical expenses are incurred). Various limitations are generally placed on certain types of elective care or in instances where diagnosis and treatment are broadly defined. Thus, for example, benefits for dental care, mental health care, alcoholism and drug abuse, and preventive care are usually limited. Many of the benefits under the plans are subject to various cost-sharing arrangements (including deductibles, coinsurance rates, and copayments). Plans may not deny a covered person benefits because of a preexisting physical or mental condition, nor may they require a waiting period before coverage begins.

VIII. FINANCING

A. Premium Rates

The FEHBP law stipulates that premium rates must reasonably and equitably reflect the cost of the benefits provided and that the rates of the two Government-wide plans must be determined on a basis which, in the judgment of OPM, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. Any readjustment in rates must be made in advance of the contract term in which they will apply and on a basis which, in the judgment of OPM, is consistent with the general practice of carriers which issue group health benefit plans to large employers. Rates are calculated for each option (high or standard), and for Self Only and Family coverage.

The premium for a particular plan is arrived at through negotiations between the plan and OPM in the year prior to the calendar (or "contract") year during which the rate will apply. The premium amount includes: the estimated cost of benefits in the contract year; an amount (usually a specified percent of premium income) for the carrier's operating expenses and service charge (or profit); an administrative reserve (no more than 1 percent of premium) to pay the administrative expenses of OPM; and a contingency reserve for each plan (no more than 3 percent of premium) to be used as a safeguard against unforeseen costs during the contract year. By law, the contingency reserves may be used to defray increases in future premium rates, to reduce the employee and Government contributions, or to increase plan benefits.

B. Contributions

The cost of the FEHBP premiums is shared by the Government and by enrolled employees and annuitants. Prior to 1971, the Government contribution was equal to 50 percent of the plan premium, with certain minimum and maximum amounts applicable to both the Government, employees, and annuitants depending on the type of plan selected.[140] By agreeing to match a "rich," "thin," or "in-between" health benefit package, the Federal Government was indicating its willingness to foster the broadest forms of health services while giving the employees free choice among alternative plans.[141]

At the same time, however, the committees recognized that "medical care costs will undoubtedly fluctuate and that the Congress will continue to be responsive . . . and will act appropriately to keep the FEHBP in consonance with future developments".[142] Indeed, in 1971, the Government contribution was completely altered in an effort to "provide automatic indexing . . . to reflect increases in medical price inflation".[143] Under current law, the Government portion of the premium is an amount equal to 60 percent (calculated for Self Only and Family) of the simple average of the high option premiums for the following plans, commonly known as the "Big Six" plans:

-- The Service Benefit Plan;
-- The Indemnity Benefit Plan;
-- The two employee organization plans with the largest enrollments; and
-- The two comprehensive medical plans with the largest enrollments.

However, the Government contribution may not exceed 75 percent of the total premium of a particular plan. In 1989, the Government contribution averages approximately 70 percent of the total premium cost, and the employee or annuitant's portion averages 30 percent.

The Government share of the premium is paid in two ways. Payments for current employees are made by their employing agencies from a "salaries and expenses" account in the agency's annual appropriation. Payments for annuitants under civil service retirement and other civilian retirement systems are made by OPM from an account which is part of OPM's annual appropriation.[144] The amount appropriated for the annuitant premiums is based on estimates by OPM of premium rates, enrollment patterns, and numbers of annuitants who are expected to receive benefits during the fiscal year.

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[140] Prior to FEHBP's authorization, both the Bureau of the Budget (now known as the Office of Management and Budget) and the Civil Service Commission (now known as the Office of Personnel Management) proposed that the Government share of the FEHBP premium be set at one-third instead of one-half.

[141] Senate Report No. 86-468, p. 15.

[142] Senate Report No. 86-468, p. 16.

[143] TPF and C, p. 29.

[144] An exception is for USPS annuitants, whose Government share of the FEHBP plan premium is paid by the USPS.

The U.S. Postal Service (USPS), under a collective bargaining agreement negotiated with its employees, pays a higher percentage of the health benefits premium than do other Government agencies. Since July 21, 1975, the USPS share has been 75 percent of the average rate of the Big Six plans, not to exceed 93.75 percent of any individual plan's rate. The higher USPS contribution applies only to contributions on behalf of active USPS employees. USPS annuitants receive the same Government contribution (and, therefore pay the same premium) as other annuitants or non-USPS employees.

The balance of the total premium not paid for by the Government is paid by the enrollees, generally: (1) by employees through salary withholdings, or (2) by annuitants through annuity withholdings. Payroll or annuity deductions were incorporated into the FEHBP design as a way to ensure comparability with typical private sector practice.

As mentioned earlier, the cost of the FEHBP premium is shared by enrollees and by the Federal Government. The Government contribution is calculated according to a formula using 60 percent of the simple average of the premiums of the Big Six FEHBP plans. Since 1983, the Big Six have been as follows:

- Blue Cross/Blue Shield High Option;
- Aetna High Option;
- Government Employees Hospital Association (GEHA);
- Mail Handlers High Option;
- Kaiser Foundation Health Plan of Northern California; and
- Kaiser Foundation Health Plan of Southern California.

Because the plans composing the Big Six can change as enrollments change, and because the premiums of the Big Six plans vary, the average Government contribution as a percent of the average total premium varies from year to year. For example, the Government share has increased from 62 percent of the total premium in 1980 to 71 percent in 1989.

C. Funds

By law, all premium contributions, including those from employees, annuitants, and the Government, are credited to a trust fund (the Employees Health Benefits Fund) which is part of the U.S. Treasury and is administered by OPM. To provide an additional source of income, the Secretary of the Treasury has the legal authority to invest and reinvest any Fund assets in interest-bearing securities of the United States. Interest on, and proceeds from the sale of, these obligations are also credited to the Fund. The FEHB Fund is charged for plan expenses, OPM's administrative expenses, and contingency reserves spent for unforeseen costs during the year.

IX. ADMINISTRATION OF THE FEHBP

A. Office of Personnel Management

The FEHB Act provided OPM with the overall responsibility for administering FEHBP. OPM is authorized to contract with the participating insurance carriers, approve qualified health benefits plans for participation in the program, negotiate with plans about benefit and premium levels, determine the times and conditions for "open season," make information available to employees concerning the plan options, and administer the FEHB Fund.

In addition, OPM supervises all health insurance activities for annuitants. In this capacity, OPM determines whether retiring employees or survivor annuitants meet the requirements to continue health coverage; takes the action necessary to terminate, accept, or continue enrollment; oversees the automatic deduction of premiums from the monthly annuity checks which are then credited, along with the applicable Government contribution, to the FEHB Fund; processes all enrollment changes; notifies affected carriers and enrollees of any enrollment changes; and keeps enrolled annuitants advised of rate and benefit changes within their plans.

B. Federal Agencies

The employing agencies supervise most health insurance activities for their employees according to procedures prescribed by OPM. To ensure that FEHBP is consistent Government-wide, the legal and regulatory standards for the program are codified in manuals which OPM distributes to the agencies. If a legal or regulatory change is made, OPM notifies the agencies through Federal Personnel Manual bulletins and letters.

OPM's contact with employees (except for its own employees) is for the most part indirect. Agencies are provided with brochures and a general information pamphlet to be given to all incoming employees who are eligible to participate in the program. Through the agencies, OPM supplies employees with notices of upcoming open seasons, plan brochures, and instructions on how to change enrollment.

The agency withholds the employee contribution toward the premium and applies the relevant Government contribution. Notification of this action is forwarded to OPM where the proper amount is credited to the FEHB Fund. Payment then flows from the U.S. Treasury to the carriers and is charged to the Fund. Each agency must keep records and information on withholdings from employee salaries and agency contributions, enrollment statistics, and any other necessary data.

C. Congress

While the establishment of FEHBP was being considered, a House Committee on Post Office and Civil Service report noted that providing a health benefits program represented an entirely new area of Federal fringe benefits in which the Federal Government was without experience. Therefore, "extreme care would be necessary, particularly in the initial stages, to protect the Government and its employees."[145] Since 1959, Congress's role has been one of both oversight and, in the last decade, more active involvement in specifying the operation of FEHBP.

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[145] House Report No. 86-957, p. 3.

D. Carriers

The carriers that participate in FEHBP bear the ultimate financial responsibility for their plan operations. This means that, in the event a plan withdraws from the program after a year in which premium payments were not adequate to cover the cost of the medical services used by enrollees, the plan must absorb the financial loss. On a continuing basis, each carrier is required to furnish OPM with statistical data with respect to the plan's operation and any other data which might be requested. All carrier operations are subject to audit. Financial reports must be submitted within 90 days after the end of the contract term.

D. Contract Process

An important aspect of OPM's responsibility is the annual contract negotiations with each FEHBP plan. During the negotiations, OPM and the plans agree to specific terms and conditions each party is obligated to meet in the next contract year. OPM begins the negotiations early each year by sending out a "call letter" to all participating plans requesting them to submit their benefit and rate proposals for the next contract year.

Next, proposals for rate increases are studied in relation to the cost of new benefits or the extension of others, the plan's past experience, utilization, and rising medical costs. A letter is sent to each carrier approving or disapproving the various proposals for benefit and rate changes. At this point, descriptions of both covered and excluded health services are incorporated into the contracts, and brochures describing these benefits are printed. The brochures are binding statements of benefits and exclusions that plans must follow as parties to FEHBP contracts. OPM then announces an open season, which generally takes place each year during late November and early December. Plan brochures and enrollment information are made available to employees to help them make their selections during the open season. The new contract year, with any benefit and rate changes, begins in early January of the following year.

APPENDIX C. THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: LEGISLATIVE HISTORY AND RELATED LEGISLATION

In the 29 years since the Federal Employees Health Benefits (FEHB) Act was authorized, the legislation that established the Federal Employees Health Benefits program (FEHBP), P.L. 86-382 has been amended many times. Related legislation has also been passed which affects FEHBP in significant ways.

The historical trend in legislative activity over the past 29 years can be summarized primarily in terms of FEHBP expansion. For example:

- Eligibility to enroll in FEHBP has been extended to more and more categories of Federal employees, annuitants, and their families and ex-family members;
- the kinds of health benefits offered through FEHBP plans have been broadened;
- the types of providers authorized to provide service and receive reimbursement under FEHBP have been expanded;
- new types of service delivery systems authorized to participate in FEHBP have been added; and
- the Government share of the premium cost has increased, as the program strives to offer participants affordable health premiums as well as plans that are comparable to those available in the private sector.

The following presents a brief description of the original and amending legislation passed between 1959 and 1988. Brief summaries of related legislative activity impacting FEHBP are also included.

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND RELATED LEGISLATION (1959-1988)

The Federal Employees Health Benefits Act of 1959 (P.L. 86-382), September 28, 1959

Effective July 1, 1960, the Federal Employees Health Benefits Act of 1959 authorized the creation of the Federal Employees Health Benefits program (FEHBP) for the Federal workforce. P.L. 86-382 and its subsequent amendments established the parameters for program operation regarding eligibility for benefits and election of coverage by participants; the types of health benefit plans that may be offered; the types of benefits that may be provided; the role of the Civil Service Commission[146] (specifically regarding contracting authority and program administration); the level of Government contributions; the establishment of an Employees Health Benefits Fund to pay for program expenses; the creation of an advisory committee; and provisions for studies, reports, and audits.

FEHBP-eligible participants specified in the enacting legislation included current Federal employees, and annuitants who retired *after* July 1, 1960, either on an immediate annuity with at least 12 years of service or for a disability. Annuitants were also required either to be enrolled in a FEHBP plan for at least 5 years immediately prior to retirement or enrolled from the earliest opportunity to do so. Family members of employees and annuitants were also eligible.[147]

The Postal Employees Salary Increase Act of 1960 (P.L. 86-568), July 1, 1960

P.L. 86-568 authorized FEHBP coverage for Agriculture Stabilization and Conservation County Committee employees.

The Retired Federal Employees Health Benefits Act (P.L. 86-724), September 8, 1960

Effective July 1, 1961, the Retired Federal Employees Health Benefits Act of 1960 authorized the creation of a health benefits program for Federal employees who retired or became disabled *before* July 1, 1960, including family members. Patterned after the already existing FEHBP for employees and annuitants who retired *after* July 1, 1960, P.L. 86-724 set forth the provisions of what became known as the "retired FEHBP" regarding Government contributions and withholdings to pay for plan premiums; participant election of coverage; provisions for a single Government-wide plan and other health benefits plans; the establishment of a retired Employees Health Benefits Fund; and suggested administrative guidelines for the Civil Service Commission to follow when promulgating retired FEHBP regulations. In 1974, annuitants participating or eligible to participate in the *retired* FEHBP and their family members were permitted to participate in the *regular* FEHBP. (See P.L. 93-246.)

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[146] The Civil Service Commission is now known as the Office of Personnel Management (OPM).

[147] Detailed program description can be found in appendix B.

To Amend the Federal Employees Health Benefits Act of 1959 to Provide Additional Choice of Health Benefits Plans, and for Other Purposes (P.L. 88-59), July 8, 1963

This Act extended through January 1, 1964 the period during which time applications from qualified employee organizations wanting to participate in the FEHBP were accepted.

To Amend the Federal Employees Health Benefits Act of 1959 to Remove Certain Inequities in the Application of Such Act, to Improve the Administration Thereof, and for Other Purposes (P.L. 88-284), March 17, 1964

This Act made the first major amendments to the FEHB Act of 1959. It broadened FEHBP coverage to include employees concurrently receiving compensation as the result of an on-the-job injury, as well as foster children and unmarried children to age 21 (raised from age 19). P.L. 88-284 also liberalized the requirements for employees to continue their FEHBP coverage into retirement by enabling them to continue coverage if they were enrolled in a FEHBP plan by December 31, 1964.[148]

At the request of the Civil Service Commission, P.L. 88-284 also gave the Commission discretionary authority to terminate FEHBP plan contracts with any carrier who did not enroll at least 300 employees and annuitants (exclusive of family members) during the preceding two contract terms. Finally, P.L. 88-284 made the Government contribution toward the cost of the health plan premium the same for *all* enrollees, regardless of gender.[149]

To Amend the Federal Employees Health Benefits Act of 1959 and the Federal Employees Group Life Insurance Act of 1954 (P.L. 88-531), August 31, 1964

This amendment authorized FEHBP coverage for certain United States Commissioners to whom the Civil Service Retirement Act applies.

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[148] Under the FEHB Act of 1959, to continue health benefits coverage into retirement an annuitant had to have had at least 5 years of FEHBP coverage immediately prior to retirement *or* had to have been enrolled in FEHBP continuously from the first opportunity to enroll (See P.L. 86-382). Many employees had not realized the importance of enrolling at their first opportunity and, without P.L. 88-284, would have been ineligible to continue their FEHBP enrollment into retirement.

[149] The original FEHB Act, P.L. 86-382, provided for a smaller Government contribution for women enrolled in a family plan.

To Amend the Federal Employees Health Benefits Act of 1959 and the Federal Employees Group Life Insurance Act of 1954 (P.L. 88-631), October 6, 1964

P.L. 88-631 authorized FEHBP coverage for teachers in the District of Columbia if they had been temporarily employed as teachers for a total of at least 2 years.

To Preserve the Benefits of the Civil Service Retirement Act, the Federal Employees Group Life Insurance Act of 1954, and the Federal Employees Health Benefits Act of 1959 for Congressional Employees Receiving Certain Congressional Staff Fellowships (P.L. 89-379), March 30, 1966

This legislation extended FEHBP coverage to congressional employees receiving certain congressional staff fellowships.

The Federal Salary and Fringe Benefits Act of 1966 (P.L. 89-504), July 18, 1966

The Federal Employees Salary and Fringe Benefits Act of 1966 amended FEHBP to change the fixed-dollar Government contribution toward the cost of the plan premium. The biweekly contribution for Self Only enrollment went from between $1.25 and $1.75 to $1.62; the biweekly contribution for Family enrollment went from between $3.00 and $4.25 to $3.94, not to exceed 50 percent of the total premium.

In addition, FEHBP coverage for dependent children was extended from age 21 to age 22, and employees on leave without pay who were serving as full-time officers or employees of Federal employee organizations were permitted to continue or acquire coverage.

To Enact Title 5, United States Code, "Government Organization and Employees," Codifying the General and Permanent Laws Relating to the Organization of the Government of the United States and to its Civilian Officers and Employees (P.L. 89-554), September 6, 1966

This Act provided for the revision and codification of laws relating to the organization of the Government of the United States and its civilian officers and employees. The FEHBP section is contained in title 5, Chapter 89.

To Amend Title 5, 14, and 37, United States Code, to Codify Recent Law, and to Improve the Code (P.L. 90-83), September 11, 1967

These amendments codified the provisions enacted by P.L. 89-504, the Federal Salary and Fringe Benefits Act of 1966.

The National Guard Technicians Act of 1968 (P.L. 90-486), August 13, 1968

National Guard technicians were converted to Federal employee status effective January 1, 1969, and the National Guard Technicians Act of 1968 authorized their coverage under FEHBP.

The Federal Magistrates Act (P.L. 90-578), October 17, 1968

The Federal Magistrates Act conferred FEHBP coverage on United States magistrates and their clerical and secretarial assistants.

The Foreign Assistance Act of 1969 (P.L. 91-175), December 30, 1969

The Foreign Assistance Act of 1969 granted employees the option of continuing participation in FEHBP during a period of transfer to employment with an international organization.

An Act to Increase the Contribution by the Federal Government to the Cost of Health Benefits Insurance, and for Other Purposes (P.L. 91-418), September 25, 1970

The determination of the Government contribution toward the employees' health plan premium was completely altered by P.L. 91-418, in an effort to "provide automatic indexing of the Government contribution to reflect increases in medical price inflation."[150]

Beginning with the first pay period in 1971, P.L. 91-418 established what is commonly referred to as the Big Six formula, equal to the simple average of the premiums for Self Only and Family coverage (using the high option where a high and standard option are offered) of the two Government-wide plans, and the two employee organization plans and the two HMOs with the highest enrollment. P.L. 91-418 set the Government contribution at 40 percent of the simple average of the Big Six premiums.

P.L. 91-418 also permitted family members who received an immediate annuity as the survivor of an employee or of a retired employee to continue enrollment in a FEHBP plan in the event that the deceased had completed less than 5 years of creditable service. FEHBP coverage was also extended to noncitizen employees whose permanent duty station is in the Panama Canal Zone.

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[150] Towers, Perrin, Forster, and Crosby, Inc. *Study of the Federal Employees Health Benefits Program*. Washington, 1988. p. 29.

The Intergovernmental Personnel Act of 1970 (P.L. 91-648), January 5, 1971

The Intergovernmental Personnel Act provided for the maintenance of FEHBP eligibility and coverage for Federal employees who were assigned to State or local governments, and extended FEHBP coverage to State or local government employees who were assigned to an executive agency (where there would otherwise have been a loss of coverage in a group health benefits plan, the premium of which was paid in whole or in part by the State or local government).

To Extend Civil Service Federal Employees Group Life Insurance and Federal Employees Health Benefits Coverage to United States Nationals Employed by the Federal Government (P.L. 93-160), November 27, 1973

This legislation extended FEHBP coverage to otherwise eligible United States nationals employed by the Federal Government at permanent duty stations outside the United States and the Panama Canal Zone.

The Health Maintenance Organization and Resources Development Act of 1973 (P.L. 93-222), December 29, 1973

The Health Maintenance Organization Act of 1973 amended the Public Health Service Act to, among other things, provide assistance and encourage the establishment and expansion of health maintenance organizations (HMOs).[151] P.L. 93-222 defined the term *HMO* as a legal entity organized and operated in a specified manner providing basic and supplemental health services to its members.

This legislation authorized the Secretary of Health and Human Services to make grants or contract with public or nonprofit private entities to determine the feasibility of developing, operating, or expanding the operation of HMOs. In addition, funding was made available to plan for the establishment of HMOs and to increase the number of geographic areas and participants served by them. The Federal Government also made loans available to assist HMOs in meeting their initial operating costs.

The HMO and Resources Development Act also mandated that employers with 25 or more employees who were required by the Fair Labor Standards Act of 1938 to pay the minimum wage must include an HMO as an option in any health benefits package offered to their employees.

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[151] Health maintenance organizations are referred to as *comprehensive medical plans* in the FEHBP authorizing legislation.

An Act to Increase the Contribution of the Government to the Costs of Health Benefits for Federal Employees, and for Other Purposes (P.L. 93-246), January 31, 1974

For pay periods commencing in 1974, P.L. 93-246 increased the Government contribution toward the FEHBP plan premium from 40 percent (established by P.L. 91-418) to 50 percent of the simple average of the Big Six premiums. A provision to increase the Government contribution to 60 percent of the Big Six average premiums for pay periods commencing in 1975 and thereafter was also included in the Act. A maximum was set on the Government contribution so that it does not exceed 75 percent of the total premium amount for any one health plan. (Previously, the Government contribution was not to exceed 50 percent of the total premium amount for any one plan. See P.L. 89-504.)

P.L. 93-246 also provided that annuitants participating or eligible to participate in the health benefits program offered under *retired* FEHBP (P.L. 86-724) could elect to be covered under *regular* FEHBP (P.L. 86-382).

Finally, health insurance plans participating in FEHBP were required to comply with OPM's decision in disputes regarding whether or not an individual was entitled to a health benefit.

To Provide Access for all Duly Licensed Clinical Psychologists and Optometrists Without Prior Referral in the Federal Employee Health Benefits Program (P.L. 93-363), July 30, 1974

This Act provided that if a plan (except a group practice plan) covers the services of licensed or certified optometrists or clinical psychologists, it cannot require referral or supervision by another practitioner as a condition for payment or reimbursement.

To Amend Chapter 83 of Title 5, United States Code, to Establish Time Limitations in Applying for Civil Service Retirement Benefits, and for Other Purposes (P.L. 94-183), December 31, 1975

These amendments redesignated title 5, section 8902, subsection (j) regarding services performed by a licensed clinical psychologist or optometrist as title 5, section 8902, subsection (k).

To Amend Title 5, United States Code, to Grant Court Leave to Federal Employees When Called as Witnesses in Certain Judicial Proceedings, and for Other Purposes (P.L. 94-310), June 15, 1976

These amendments provided that Government contributions toward the health plan premium for annuitants were to be paid from annual appropriations authorized for that purpose and were to be made available until expended.

To Amend Title 5, United States Code, to Restore Eligibility for Health Benefits Coverage to Certain Individuals Whose Survivor Annuities are Restored (P.L. 94-342), July 6, 1976

P.L. 94-342 provided that a surviving spouse who was covered under FEHBP when the survivor annuity was terminated because of remarriage is eligible to re-enroll in FEHBP if the survivor annuity is restored.

The Health Maintenance Organization Amendments of 1976 (P.L. 94-460), October 8, 1976

These amendments provided that an entity providing health services on a prepaid basis to a defined population (which includes FEHBP enrollees) is eligible to receive assistance of the type specified in P.L. 93-222 *if*, with respect to its *other* members, it provides health services and is organized and operated in accordance with certain provisions.

To Amend Chapter 89 of Title 5, United States Code, to Establish Uniformity in Federal Employee Health Benefits and Coverage by Preempting Certain State or Local Laws Which are Inconsistent with such Contracts, and for Other Purposes (P.L. 95-368), September 17, 1978

This Act established uniformity in benefits and coverage under FEHBP by preempting certain State and local laws which were inconsistent with FEHBP contracts. P.L. 95-368 also provided that for 5 years (beginning January 1, 1980 and ending December 31, 1984), if the Federal insurance contract provided or paid for the cost of a certain health service, the insurance carrier would be required to pay, up to the limits of its contract, for any health practitioner who is licensed by a State to provide that service if the recipient is in a medically underserved area. (This provision did not apply to group practice plans.)

P.L. 95-368 also changed the requirement in P.L. 88-59 (that barred employee organizations from applying to sponsor a health benefit plan after January 1, 1964), permitting such organizations to apply between December 31, 1978 and January 1, 1980.

The Federal Employees Part Time Career Employment Act of 1978 (P.L. 95-437), October 10, 1978

The Federal Employees Part Time Career Employment Act of 1978 provided FEHBP coverage to part-time career employees.

The Civil Service Reform Act of 1978 (P.L. 95-454), October 13, 1978

The Civil Service Reform Act of 1978 amended title 5, Chapter 89 by striking out "Civil Service Commission" and "Commission" wherever they appeared and inserting instead "Office of Personnel Management" and "Office," respectively.

To Amend Subchapter III of Chapter 83 of Title 5, United States Code, to Provide that Employees who Retire After 5 Years of Service, in Certain Instances, May be Eligible to Retain their Life and Health Insurance Benefits, and for Other Purposes (P.L. 95-583), November 2, 1978

This Act reduced from 12 years to 5 years the length of creditable service required by a retiring employee in order to retain FEHBP coverage into retirement. (See P.L. 86-382)

To Make Certain Technical and Clerical Amendments to Title 5, United States Code (P.L. 96-54), August 14, 1979

These amendments redefined "employee" for the purpose of FEHBP coverage to exclude the previous reference to the United States Commissioner (see P.L. 88-531), and to include employees of Gallaudet College and certain county committee employees. In addition, the amount of the Government contribution[152] toward the plan premium and the effective date of the adjustment for employees and for annuitants was clarified.[153]

The Panama Canal Act of 1979 (P.L. 96-70), September 27, 1979

The Panama Canal Act of 1979 redefined the term "employee" for the purposes of FEHBP eligibility to exclude individuals who were not citizens or nationals of the United States, and whose permanent duty station was outside the United States, *unless* the individual was an employee on September 30, 1979, by reason of service in an executive agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Panama Canal Zone.

To Amend the Retired Federal Employees Health Benefits Act, as Amended, with Respect to the Government Contribution Toward [the] Subscription Charge (P.L. 96-156), December 27, 1979

Effective January 1, 1980, P.L. 96-156 provided that if a retired employee enrolls for Self Only FEHBP coverage, the monthly Government contribution must equal the current monthly premium under section 1839(c)(3) of the

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[152] The Government contribution was equal to 60 percent of the simple average of the Big Six premiums. (See P.L. 91-418 and P.L. 93-246.)

[153] For employees, the adjustment period was to begin on the first day of the employee's first pay period of each year. For annuitants, the adjustment was to begin on the first day of the first period of each year for which an annuity payment was made.

Social Security Act. Retired employees enrolled in Family coverage receive a Government contribution twice that for retirees enrolled for Self Only.[154]

To Amend Provisions of Chapters 83 and 89 of Title 5, United States Code, Which Relate to Survivor Benefits for Certain Dependent Children, and for Other Purposes (P.L. 96-179), January 2, 1980

This legislation eliminated the "lives with" requirement for a natural child to be covered by FEHBP and added a dependency requirement for all children. P.L. 96-179 also redefined the term "medically underserved population" for the purpose of making benefit payments under FEHBP.

The Federal Courts Improvement Act of 1982 (P.L. 97-164), April 2, 1982

The Federal Courts Improvement Act of 1982 amended title 5, section 8912 to strike out "Court of Claims" wherever it appeared and insert instead "United States Claims Court."

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), September 3, 1982

Effective January 1, 1983, the Tax Equity and Fiscal Responsibility Act of 1982 established Medicare coverage for certain Federal employees age 65 or over and set forth the application of the Hospital Insurance tax to Federal employment. Federal employees who met the age requirement, the definition of having Medicare-qualified employment, and who applied for coverage were entitled under Part A of title XVIII of the Social Security Act to Medicare hospital benefits, regardless of whether they were also enrolled in other health benefits plans.

P.L. 97-248 also provided that Medicare payments are secondary for services provided to employees aged 65 to 69 (and their spouses aged 65 to 69) if covered under certain employer group health plans, including FEHBP.

To Amend Title 5, United States Code, to Provide Training Opportunities for Employees Under the Office of the Architect of the Capitol and the Botanic Garden, and for Other Purposes (P.L. 97-346), October 15, 1982

These amendments required the Office of Personnel Management (OPM) to determine the difference between the amount of the Government contribution for 1983 and the amount such contributions *would have been* if the two employee organizations included in the 1981 Big Six formula were included in the 1983 Big Six formula. P.L. 97-346 required the Government to pay the difference into the contingency reserves of all FEHBP plans for 1983 in proportion to the number of enrollees in each plan.

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[154] Under the original retired FEHBP, the Government contribution was set between $3 and $4 per month for Self Only enrollment, and between twice these amounts for Family enrollment, with OPM prescribing the exact amount.

The Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), November 8, 1984

In 1984, the Civil Service Retirement and Spouse Equity Act extended eligibility for FEHBP coverage to former spouses of employed, retired or separated Federal employees. The former spouse must pay both the employee and the Government share of the premium.

An Act to Provide that Employee Organizations Ineligible to Participate in the FEHBP Solely Because Applications for Approval Must be Filed Before January 1, 1980, May Apply to Become so Eligible, and For Other Purposes (P.L. 99-53), June 17, 1985

This legislation authorized the establishment of additional Federal employee health benefit plans for members of an employee organization *if* the employee organization applied to OPM within 90 days of the enactment of P.L. 99-53 for plan approval. Also specified were the conditions required for plan approval.

In addition, this Act permitted certain disability annuitants who were later restored to Federal employment to enroll in a FEHBP plan if the annuitant had been enrolled in any such plan immediately prior to termination of employment.

The Federal Employees Benefits Improvement Act of 1986 (P.L. 99-251), February 27, 1986

The Federal Employees Benefits Improvements Act of 1986 made many changes to FEHBP. It added a new type of health plan composed of hybrids of prepaid group practice plans or individual practice plans to participate in FEHBP.[155] Additionally, the requirement that there be at least three medical specialties for group practice prepayment plans was eliminated.

In terms of expanding coverage to new types of health practitioners, this legislation mandated studies to be undertaken by OPM regarding extending FEHBP contracting authority to health practitioners who were not currently covered (such as nurse midwives and chiropractors).[156] Contracting authority was also extended to clinical social workers, although health plans were permitted to require referral by a psychiatrist as a condition for reimbursement.

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[155] These hybrids of group practice plans or individual practice plans are referred to in the law as *mixed model plans*.

[156] OPM released this study, entitled *A Study Relating to Expanding the Class of Health Practitioners Authorized to Receive Direct Payment or Reimbursement in Accordance with 5 U.S.C., 8902(k)(1)*, in Mar. 1986.

P.L. 99-251 also expressed the sense of Congress that enrollees in FEHBP should receive adequate treatment for mental illness, alcoholism, and drug addiction. In addition, OPM was directed to study the adequacy of the FEHBP information materials disseminated to employees during the open enrollment season.[157]

This legislation also permitted OPM to waive certain plan election requirements in cases of exceptional circumstances and to provide a 3-week period during which enrollees may change or cancel their enrollment in the event that rates or benefits changed, a new plan is offered, or an existing plan is terminated. Enrollees were authorized to transfer at other times and under such circumstances as prescribed by OPM.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), April 7, 1986

The Consolidated Omnibus Budget Reconciliation Act of 1985 required OPM to determine the minimum level of financial reserves which must be held by each carrier in order to ensure stable and efficient operation of the health plan. P.L. 99-272 set forth provisions regarding minimum amounts to be refunded, and the use of such amounts. Reserves held in excess of such minimum levels were to be returned to the Employees Health Benefits Fund.

In addition, the USPS was required to pay the Government share of the health plan premium beginning October 1, 1986 for postal employees who first became annuitants because of retirement.

The Federal Employees' Retirement System Act of 1986 (P.L. 99-335), June 6, 1986

These amendments to title 5, chapter 89 provided FEHBP eligibility to individuals first employed by the Government of the District of Columbia before October 1, 1987. The definition of an annuitant was also incorporated as an employee retiring on an immediate annuity after 5 or more years of creditable service or for a disability. Technical corrections were also made.

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[157] OPM released this study, entitled *A Study of the Adequacy of Information Materials under the Federal Employees Health Benefits Program*, in May 1986.

The Federal Employees Retirement System Technical Corrections Act of 1986 (P.L. 99-556), October 27, 1986

This Act provided clarification relating to the eligibility of certain survivor annuitants to participate in FEHBP and made technical amendments to P.L. 98-615, the Civil Service Retirement Spouse Equity Act of 1984.

The Intelligence Authorization Act for Fiscal Year 1987 (P.L. 99-569), October 27, 1986

The Intelligence Authorization Act for Fiscal Year 1987 provided health benefits for certain former spouses of Central Intelligence Agency employees.

The Anti-Drug Abuse Act of 1986 (P.L. 99-570), October 27, 1986

This Act expressed the sense of Congress that all employers providing health insurance policies should ensure that the policies provide adequate coverage for treatment of drug and alcohol addiction.

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), December 22, 1987

The Omnibus Budget Reconciliation Act specified the amount ($160 million in FY 1988, and $270 million, in FY 1989) of the contributions to be made by the USPS to the Employees Health Benefits Fund to pay the Government share of the health plan premium for certain annuitants and survivor annuitants.

The Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204), December 22, 1987

The Foreign Relations Authorization Act provided FEHBP coverage for certain former spouses of employees or former employees of the Foreign Service.

The Federal Employees' Retirement System Technical Corrections Act (P.L. 100-238), January 8, 1988

This Act declared that certain nonfederal employees who were eligible for FEHBP benefits (as well as other benefits such as Federal Employees Group Life Insurance) were no longer entitled to such benefits after October 1, 1988.

P.L. 100-238 also continued FEHBP coverage for employees of St. Elizabeths Hospital who became District of Columbia employees due to the Federal Government's transfer of the hospital to the District of Columbia.

Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), July 1, 1988

The Medicare Catastrophic Coverage Act of 1988 required OPM to reduce the rates charged to Medicare-eligible individuals who were also participating in FEHBP. The Act specified that health premiums were to be reduced by the amount (prorated for each covered Medicare-eligible individual) of the estimated cost of medical services and supplies which *would have been* incurred by FEHBP had the Medicare catastrophic coverage benefit not been enacted.[158]

This legislation also required OPM to submit a report to Congress by April 1, 1989 regarding changes to FEHBP that may be required in order to incorporate health benefit plans designed specifically for Medicare-eligible individuals[159] and to improve the efficiency and effectiveness of the program. OPM was also required to submit a separate report to Congress by April 1, 1989 on the feasibility of adopting the National Association of Insurance Commissioners standards when providing Medicare supplemental health benefit plans under FEHBP.

The Treasury, Postal Service, and General Government Appropriations Act, 1989 (P.L. 100-440), September 22, 1988

This Act provides that no funds appropriated by P.L. 100-440 are available to pay for an abortion. In addition, no funds are available to pay for the administrative expenses of any health plan under FEHBP which provides any benefits or coverages for abortion.[160]

Similar provisions have been incorporated into Treasury, Postal Service, and General Government Appropriations Acts since 1981.

Federal Employees Health Benefits Amendments Act of 1988 (P.L. 100-654), November 14, 1988

The Federal Employees Health Benefits Amendments Act of 1988 set forth provisions regarding the authority of OPM to impose debarment and other sanctions on health care providers convicted of, among other things, financial misconduct, neglect or abuse of patients, the unlawful manufacture, distribution, or dispensing of a controlled substance, and interference with, or obstruction of, an investigation or prosecution of the aforementioned or other criminal offenses. P.L. 100-654 set forth time limits within which OPM must initiate a debarment proceeding and prohibited providers without a valid license from participating in FEHBP. This legislation also authorized OPM to impose monetary penalties on providers who made false charges or claims in connection with providing health services or supplies.

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[158] The Director of OPM announced on October 26, 1988 that the premium reduction for 1989 would be $3.10 per month for each Medicare-eligible individual also participating in FEHBP.

[159] These plans are often referred to as Medicare supplemental health plans or "medigap" plans.

[160] This provision is waived where the life of the mother would be endangered if the fetus were carried to term.

The Federal Employees Health Benefits Amendments Act of 1988 also contained provisions, effective for the 1990 contract year, relating to the temporary continuation of health benefits coverage with no Government contribution for Federal employees separated from service for reasons other than gross misconduct, or for individuals no longer meeting unmarried dependent child requirements.

In addition, OPM was directed to prescribe regulations offering health benefits coverage to temporary Federal employees who have completed one year of continuous service, with such employees paying the total premium amount.

APPENDIX D. GLOSSARY

Actuarial Benefits Value. The value of a health plan's benefits. The methodology for determining this value may be based entirely on a plan's provisions, or may adjust for the geographic location and demographic characteristics of enrollees, the actual health care utilization level by plan participants, or the type of plan under which the benefits are provided (e.g., fee-for-service plan vs. health maintenance organization). The method used in this report takes into account both a plan's provisions and the characteristics of the plan's enrollees.

Adverse Selection. The congregation of individuals who use more health care than average (i.e., who are higher risks) in particular health plans.

Carrier. An insurance company or sponsor that underwrites or administers a program that pays for health services.

Catastrophic Expense Protection (or Out-of-Pocket Limit). A health plan benefit that limits the amount the enrollee must pay out-of-pocket for plan cost sharing for covered services. Once the catastrophic limit is reached, plans generally pay for any additional covered expenses in full.

Coinsurance. A fixed percentage of covered expenses paid by the health plan and the enrollee for covered expenses after the deductible has been met. For example, 80/20 coinsurance means 80 percent is paid by the plan and 20 percent is paid by the enrollee.

Coordination of Benefits. A method of integrating the benefits payable under more than one health plan so that the enrollee's benefits from all do not exceed 100 percent of the allowable medical expenses. The plan that pays its benefits first is known as the **primary payer**, and the plan paying for remaining benefits is called the **secondary payer**. Under FEHBP, for example, if the enrollee is a retiree who no longer works and has both FEHBP and Medicare coverage, Medicare is the primary payer, paying its benefits first, and FEHBP is the secondary payer, waiving its deductibles and coinsurance to pay full, reasonable and customary charges for covered services for the amounts left unpaid by Medicare.

Copayment. A fixed dollar amount that a health plan enrollee is required to pay for a covered service (e.g., $3 per prescription drug).

Cost Sharing. Cost sharing refers to the provisions of a health benefits plan that require the enrollee to pay a portion of the cost of services covered by the plan. Typical forms of cost sharing include deductibles, coinsurance, and copayments. "Premium cost sharing" refers to the sharing of the cost of the health plan premium between the employer and the enrollee.

Covered Services. Services eligible for coverage by a health plan.

Deductible. A specified amount of money (e.g., $200) that must be paid during a given time period (usually a year) by the enrollee for covered services before any payments are made by a health plan.

Diagnosis-Related Groups (DRGs). Categories in a classification system to which hospital inpatients may be assigned according to the nature of their particular medical condition (for example, heart attack). DRGs attempt to classify patients into clinically coherent and similar groups with respect to resource use. The DRGs are the basis for payment in a number of prospective hospital payment systems, including those of Medicare and CHAMPUS.

Employee Organization Plan. The term used in FEHBP to describe the fee-for-service plans sponsored by Federal unions and employee organizations.

Fee-for-Service (FFS) Plan. As used by OPM and others, a traditional or conventional health insurance plan that permits employees to select providers of services and pays the providers according to the fees charged for such services. The term is used to contrast such plans with health maintenance organizations, under which the enrollee generally must obtain services from the HMO providers whose payments from the HMO are not necessarily directly related to the type or quantity of services actually provided.

FEHBP Option. A level of benefit coverage offered by a plan. Under FEHBP, a plan may offer both a high option and a standard option.

FEHBP Plan. A combination of benefit coverages offered by an organization authorized to participate in FEHBP.

FEHBP Sponsor. An organization authorized to offer plans in FEHBP, including Blue Cross/Blue Shield and Aetna, employee organizations, and HMOs.

Flexible Benefits (or Cafeteria) Plan. Section 125(c) of the Internal Revenue Code defines a cafeteria (or flexible benefits plan) as a separate written benefits plan where all participants are employees who are allowed to choose between (1) cash and qualified benefits, or (2) two or more qualified benefits. Qualified benefits are the following benefits: group term life insurance, accident and health insurance, disability insurance, group legal services, dependent care assistance, 401(k) retirement saving plans, and paid leave.

Health Maintenance Organization (HMO). A type of health insurer which directly provides or arranges for medical care for its members in a defined geographic area. Except in emergencies, the HMO is financially responsible for its members' medical costs only if the members use the HMO's affiliated providers.

Insurer. Insurance company, HMO, government program, or employer responsible for providing coverage against financial loss. An employee organization sponsoring a health plan may use an insurer (for example, Mutual of Omaha or Union Labor Life Insurance Company) to insure the organization's health plan benefits.

Managed Care. A general term for organized health care delivery systems (such as HMOs) or features of health care plans (such as preadmission certification) that attempt to control or coordinate enrollees' use of services.

Medigap. A health insurance policy (also called a Medicare supplemental policy) designed to pay for services not covered by the Medicare program. Medigap policies generally cover some or all of Medicare's cost-sharing requirements and may also cover other costs or services not covered by Medicare (such as dental services).

Out-of-Pocket Expenses. Payments made by a plan enrollee for medical services that are not reimbursed by the health plan. Out-of-pocket expenses can include payments for deductibles, coinsurance, services not covered by the plan, provider charges in excess of the plan's limits, and enrollee premium payments.

Preferred Provider Organization (PPO). A term that refers to a variety of different insurance arrangements under which plan enrollees who choose to obtain medical care from a specified group of participating providers receive certain advantages, such as reduced cost-sharing charges.

Premium (or Rate). The amount that must be paid to purchase an insurance policy or keep it in effect.

Prospective Payment System. A payment system under which health care providers are paid for their services according to a predetermined, fixed amount. Although prospective payment rates may be related to the costs providers incur in providing services, the amount a provider is paid for a service under a prospective payment system is unrelated to the provider's actual cost of providing that specific service. Medicare and CHAMPUS use prospective payment systems to pay for inpatient hospital services.

Provider. An individual or institution that provides medical services (e.g., a physician, hospital, laboratory, etc). This term should not be confused with an insurance company which "provides" insurance.

Reasonable and Customary (R&C) Charge. The amount of a provider's charges that a health plan will recognize for payment. The R&C amount is usually determined as an upper limit on charges consistent with charges for that particular service in a certain geographic area.

Reserves. Premium amounts set aside by insurers to pay for current and future claims liabilities. Under FEHBP, reserve accumulations can be used as a cushion against unexpected claims or to offset future premium changes.

Retention. Administrative expense charged by an insurer and/or employee organization. These expenses may include claims payment (administration) expenses, State premium taxes, and risk charges.

Risk Segmentation (or Risk Selection). The segmentation (through choice) into separate plans of participants with similar expected demands for medical services. Risk segmentation is also known as risk selection or biased selection. The congregation of high users in a plan is known as adverse selection; the congregation of low users is known as favorable selection.

Risk Spiral. Uncontrolled risk segmentation that results in the congregation of high-risk individuals in certain plans, causing premiums of those plans to rise, which then causes other individuals (generally the lower risk or lower income) to leave those plans, increasing premiums even higher.

Self Insurance. Payment of employee health care expenses though the use of a special fund established by an employer or employee group, rather than by arranging for an insurer to provide such coverage. The employer or employee group directly assumes the functions, responsibilities and liabilities of an insurer.

Scheduled Allowance. A fixed dollar amount that a health plan will pay for a particular service.

Third-Party Payer. An organization (private or public) that pays for or insures the health care expenses of its beneficiaries. Third-party payers include Blue Cross/Blue Shield, commercial health insurers, Medicare, and Medicaid. (The individual receiving the health care services is the first party, and the individual or institution providing the service is the second party.)

APPENDIX E. LIST OF ACRONYMS[161]

ACF	Alternate Care Facility
AGI	Adjusted Gross Income
ASA	Administrative Service Agreement
ASO	Administrative Service Only
AZT	Azidothymidine
BLS	Bureau of Labor Statistics
BVC	Benefit Value Comparison
CBO	Congressional Budget Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPI	Consumer Price Index
CRS	Congressional Research Service
CSRS	Civil Service Retirement System
CY	Calendar Year
DRG	Diagnosis Related Group
ERISA	Employee Retirement Income Security Act
FEHBP	Federal Employees Health Benefits Program
FERS	Federal Employees Retirement System
FFS	Fee for Service
FY	Fiscal Year
GAO	General Accounting Office
GNP	Gross National Product
HCFA	Health Care Financing Administration
HHBR	Hay/Huggins Benefit Report
HI	Hospital Insurance (Part A, Medicare)
HIAA	Health Insurance Association of America
HMO	Health Maintenance Organization
IPA	Individual Practice Association
IRC	Internal Revenue Code
IRS	Internal Revenue Service
LOC	Letter of Credit
MPP	Minimum Premium Plan
OPM	Office of Personnel Management
PC	Personal Computer
PGP	Prepaid Group Practice
PPO	Preferred Provider Organization
PPS	Prospective Payment System
R&C	Reasonable and Customary
SA	Scheduled Allowance
SMI	Supplementary Medical Insurance (Part B, Medicare)
TPA	Third-Party Administrator
TPF&C	Towers, Perrin, Forster, & Crosby, Inc.

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[161] Exclusive of FEHBP plan names.

APPENDIX F. COMPARABILITY WITH THE NONFEDERAL SECTOR

In designing a health benefit package, an employer takes many factors into consideration. How much is the firm willing to spend? What benefits will be included? Who will administer or insure the plan? What cost containment measures will be employed? Which employees will be eligible to participate? Will employees share in the cost?

This appendix will outline typical health insurance features found in the nonfederal sector.

A. Typical Features of Nonfederal Health Plans

The BLS reports that health care benefits are provided to 95 percent of employees working for medium and large private sector firms and 94 percent of employees of State and local governments. Virtually all of the participants in health care plans are covered for the major categories of medical care, such as hospital room and board, care by physicians and surgeons, diagnostic x-ray and laboratory work, and prescription drugs.

The FEHB Team has identified the specific features commonly found in health benefit plans offered by medium and large private sector employers, as well as by State and local governments. The illustrative plan features are based primarily on the *1988 Hay/Huggins Benefits Report*, supplemented by the BLS surveys of *Employee Benefits in Medium and Large Firms, 1986*, and *Employee Benefits in State and Local Governments, 1987*.

State and local governments usually cover police, firefighters, and teachers under plans separate from regular employees. Private sector employers usually cover all eligible employees under one plan. In some cases, separate plans are maintained for union and nonunion employees. Unlike FEHBP, once a plan is established there is usually little choice offered private sector employees. The overwhelming majority (85 percent) of medium and large employers in the 1988 Hay/Huggins Benefits Report offer their employees only one FFS plan. However, in most cases (68 percent) there is at least one HMO choice. In the small number of cases (15 percent) where there is a choice between FFS plans, it is usually between a high versus a low benefit option.

Although there is a shifting toward higher deductibles, most nonfederal health plans require an overall plan deductible of $100, applicable to all covered services, with an annual limit on out-of-pocket spending of $1,000 ($2,000 for a family). A typical plan also includes in-patient hospital care as well as certain alternatives to hospital care, such as skilled nursing care in an extended care facility. The typical plan provides surgical services, nonsurgical physician services, X-ray and laboratory tests, prescription drugs, dental benefits, and mental health care (both inpatient and outpatient). The typical plan pays 80 percent of the reasonable and customary (R&C) charges for most of these services.

The typical plan features included in our analysis do not include certain other benefits such as vision care, hearing care, or routine physical exams because only a small percentage of employees are covered for them.

1. *General Plan Design*

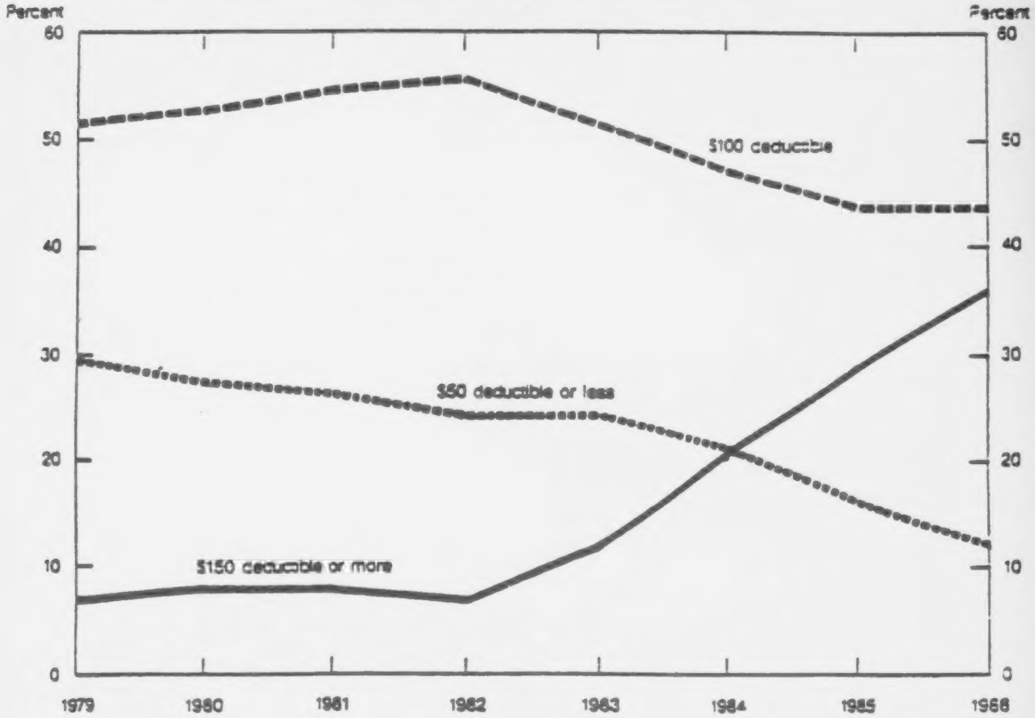
Traditionally, many health care plans covered hospital, surgical, and certain other expenses at 100 percent of R&C charges with no deductible. After a specified dollar amount of expenses was reached, additional charges were subject to a deductible and were paid at a lower coinsurance amount (typically 80 percent). These are known as "basic plus supplemental major medical" plans. However, another type of plan is becoming commonplace. It is known as "comprehensive major medical." Under this approach, generally all expenses are paid at less than 100 percent of R&C charges. As will be discussed later, the "comprehensive" approach has become more prevalent for cost containment reasons.

Some employers have developed variations of these two approaches that combine features of both "basic" and "comprehensive" design--for example, one or more deductibles, and variable coinsurance. As a result of the steadily increasing number of combination-type plans, data in the *Hay/Huggins Benefit Report* are not separately identified as "basic plus supplemental" or "comprehensive." Instead, provisions of all plans are reported without making a distinction among approaches. Thus, in developing the illustrative nonfederal plan shown in chapter 5, the most common offering is shown for each benefit feature. The combination of all these features may not produce a "typical" plan found in actual practice, but rather they make up a composite of typical plan features.

a. Overall plan deductible. Most employer plans in the *Hay/Huggins Benefit Survey* require enrollee payment of an overall annual plan deductible of $100 to $200 before the plan will pay for covered services. The lower the deductible, the more likely that the plan covers hospital and surgical services expenses at 100 percent. (Of course, this would be a more generous plan with higher premiums.) One hundred dollars is the most common deductible (found in 46 percent of the plans having a deductible), but the shift to higher deductibles continues. Forty-seven percent report a deductible greater than $100 in 1988, compared to only 11 percent 5 years ago.

The BLS survey data also show this trend. A deductible amount of $100 per year has been the most common in private sector firms since the survey's inception in 1979, currently applying to nearly half of all plan participants. However, as shown in the following chart, 36 percent of private sector participants were required to pay deductibles of $150 or more in 1986, up from about 7 percent in 1979.

CHART 1. Trends in Selected Deductible Amounts: Percent of Full-Time Participants in Major Medical Plans, Medium and Large Firms, 1979-86



Source: Bureau of Labor Statistics. *Employee Benefits in Medium and Large Firms, 1986.* June 1987.

The BLS data also show that the deductible for one-half the participants in State and local government plans who are subject to overall limits was $100, while approximately one-fourth were in plans requiring a deductible of $150 or more. The average deductible was $118 for police and firefighters, and $133 for regular employees and teachers.

b. Overall plan coinsurance. Employer plans generally pay for covered services at a specified percentage (usually 80 to 100 percent) of the actual charge, limited by what is known as the R&C charge. The plan then pays a percentage of the R&C charge. If a provider's charge for services covered by the plan exceeds the R&C limit, payment is reduced to that amount and the enrollee is responsible for the excess. Enrollee coinsurance amounts are typically counted toward the plan's out-of-pocket maximum (but not charges paid by the enrollee beyond the R&C limit).

The vast majority of firms in the Hay/Huggins survey base insurance coverage on a percentage of R&C charge, rather than a dollar schedule. The coinsurance amount is usually 80 percent. For example, 95 percent of the firms base insurance coverage for surgical services on a percentage of R&C charges, with three-fourths of these plans setting the initial coinsurance amount at 80 percent.

The majority of medical plans now have variable coinsurance arrangements whereby the coinsurance level paid by the plan generally increases as more medical expenses are incurred. The intent is to provide a limit on employee out-of-pocket costs in the event of "catastrophic" medical expenses.

The BLS survey shows that almost seven-eighths of the participants in private sector plans had 80 percent of their medical expenses paid by the plan, with the remaining 20 percent of the expenses paid by the participant. For over four-fifths of the participants, the percentage paid by the plan increased to 100 percent after a specified level of expenses was incurred during the year. For example, a plan might pay 80 percent of the first $10,000 of covered expenses and 100 percent thereafter, thus limiting the employee's out-of-pocket cost to $2,000 (in addition to the deductible).

For public sector (i.e., State and local) plans, just over three-fourths of the participants subject to overall limits were in plans that paid 80 percent of expenses, with the remaining 20 percent paid by the worker. For almost four-fifths of the participants, however, the percentage increased to 100 percent after the specified level of expenses was incurred.

c. *Annual out-of-pocket limit.* Most employer health plans place an annual maximum limit on out-of-pocket expenses paid by enrollees for covered services. Once that limit is reached, the plan pays for the full cost (100 percent) of subsequent covered expenses. However, most of the plans do not count any mental health out-of-pocket amounts toward the limit.

The annual out-of-pocket limit before a plan pays 100 percent of expenses varies from less than $500 to more than $4,000 for an individual. The most common limit found among plans in the Hay/Huggins survey was $1,000. For families, the limit clustered around $2,000.

According to BLS, outlays for covered expenses for private sector employees were capped at $1,200 or less per year for 3 out of 4 participants with "stop loss" coverage. For public sector employees where stop-loss coverage applied, outlays for covered expenses of individuals were capped at an average of $800.

The typical plan feature for the annual out-of-pocket limit is $1,000 for an individual, and $2,000 for a family.

d. *Lifetime maximum.* Most plans place a limit on the amount they will reimburse of any insured's lifetime medical expenses. Seventy percent of the plans in the Hay/Huggins survey have a lifetime maximum. In over two-thirds of the plans, the lifetime limit is $1 million or more. Thus, for all practical purposes there is no lifetime maximum, since few enrollees would have medical expenses exceeding $1 million.

Benefits for 80 percent of private sector participants in the BLS survey were found to be subject to a ceiling on the amount payable by the plan, usually a lifetime maximum. In 1986, the most common limitation was $1 million. (Two-hundred fifty thousand dollars had been the most common limit until 1985.) In 1987, 71 percent of the participants in State and local plans with overall limits were in plans with a lifetime maximum. Four-fifths were in plans with a $1 million maximum; the average lifetime maximum was $865,000.

2. *Hospital Benefits*

Hospital benefits generally provide coverage for inpatient hospital room and board costs. This includes room, meals, and services provided routinely to patients (such as general nursing services); any special care expenses (such as intensive care); other inpatient hospital services such as drugs, operating and recovery rooms, x-ray, laboratory and pathological services; and certain services in hospital outpatient departments.

a. Hospital deductible. The BLS survey of private sector firms shows that a majority of employees are in health insurance plans that cover all initial hospital room expenses; however, a growing minority must pay part of first-dollar costs. The percentage of private health plan participants with only major medical coverage increased from 19 percent in 1983, to 35 percent in 1986. These employees typically must pay both an initial deductible and a percentage of subsequent hospital room charges. For public employee plans, separate deductibles for hospital admissions had to be met by only 16 percent of the participants in 1987.

The percentage of private sector plans that require a deductible before paying for hospital expenses has increased dramatically in recent years. According to the *Hay/Huggins Benefits Report*, in 1980, 24 percent of employer health plans subjected claims for inpatient hospital services to a deductible. In 1988, that percentage increased to 55 percent. Thus, the typical plan applies a $100 deductible per person ($300 maximum per family) to hospital benefits.

b. Length of stay. The BLS surveys show that virtually all participants--both public and private--are in plans that relate the payment of basic hospital room and board coverage to the semiprivate rate. Among public plans, participants were nearly always covered for as many days of care as needed. Seventy-five percent of the private sector participants in basic hospital plans had a ceiling on the duration of coverage. Almost three-fifths had plans which specified the maximum number of days covered per confinement, most commonly 120 or 365 days.

Among private sector firms in the Hay/Huggins survey, one-quarter of the plans have unlimited stays. Another quarter limit the stay to 365 days. The next most common limit is 120 days (16 percent). Sixty-three percent of the plans in the Hay/Huggins survey have no maximum limit on the length of the hospital stay.

c. *Hospital reimbursement percentage.* Commercially insured plans generally pay for hospital room and board charges at a percentage of the prevailing semiprivate room rate (usually 80 to 100 percent). BC/BS plans generally pay the full negotiated cost of most hospital services in member hospitals; in nonmember hospitals they pay a portion of the semiprivate room rate, plus ancillary costs.

Fifty percent of the Hay/Huggins plans reimburse room and board charges at 100 percent; 40 percent of the plans reimburse at 80 percent. Less than 1 percent reimburse at less than 80 percent.

According to the BLS survey of State and local governments, about two-thirds of the participants were in plans paying the full semiprivate rate or at least the full rate for a specified period of time, after which a percentage (usually 80 percent) of the semiprivate rate was paid. The other one-third paid a percent of the semiprivate rate, usually 80 percent.

The typical plan feature used in this analysis includes payment for hospital bills at 100 percent of the hospital's semiprivate room rate for up to 365 days. Also covered at 100 percent of R&C charges are intensive care, other hospital non-room and board services, and outpatient care (both routine and emergency).

3. Hospitalization Alternatives

A variety of health care arrangements are available to treat individuals outside of the hospital setting, including skilled nursing care in an extended care facility and home health care. The cost of these services is generally believed to be offset, at least in part, by the savings achieved by treating patients in less costly settings.

Three-fourths of public plan participants are covered for services provided in extended care facilities and for home health care. These services are usually subject to a separate internal plan limit and/or overall limits (such as deductibles or coinsurance percentages).

Eighty-six percent of the plans in the Hay/Huggins survey cover home health services, typically at 80 percent of R&C charges. In addition, the proportion of plans offering extended care facility coverage has been steadily increasing, from 67 percent in 1982, to 79 percent in 1984, to 91 percent in 1988. Extended care facilities are used when an individual requires ongoing active medical and skilled nursing care. Sixty percent of the plans pay less than 100 percent of the total expense for this benefit. The typical plan feature found in the nonfederal sector provides coverage for home health care or care in an extended care facility or a skilled nursing facility at 80 percent of R&C charges.

4. *Surgical Benefits*

Surgical benefits include coverage of surgical procedures, both in the hospital and on an outpatient basis. Seventy-five percent of private health plan participants in the BLS survey had basic coverage for surgery in 1986. Over four-fifths of these participants had plans with payments based on R&C charges. Although most of these plans paid 100 percent of such charges, 12 percent of the participants were in plans that paid between 80 and 95 percent or imposed an overall dollar limit on surgical payments. The remaining one-fifth of participants with basic surgical benefits were covered by a schedule of payments, listing the maximum amount payable for each operation. Charges in excess of the scheduled amount were usually covered by a major medical plan.

The BLS survey of State and local government plans shows that surgeons' fees for operations performed in a hospital were paid in full for half of the plan participants. Plans for approximately two-fifths of the participants would pay a portion of R&C charges, typically 80 percent.

Ninety-five percent of the Hay/Huggins plans base reimbursement on a percentage of R&C charges. Sixty-three percent of these plans subject surgical benefits to a deductible before coverage begins with three-quarters of these reimbursing at 80 percent. The other 37 percent of the plans do not subject surgical procedures to a deductible. In these cases, they usually reimburse at 100 percent of R&C charges (81 percent of the plans).

The typical plan feature reimburses surgical services at 80 percent of R&C charges, after the overall plan deductible is met.

5. *Physician Services (Nonsurgical)*

Nonsurgical physician services include coverage of medical care in the physician's office, in an inhospital setting, and at home. One-third of public plan participants were covered in full for inhospital physician visits. Two-thirds were subject to either overall limits (such as deductibles or coinsurance percentages) or both overall limits and separate internal plan limits. Sixty-two percent were subject to overall plan limits for physician office visits.

Most plans in the Hay/Huggins survey (85 percent in 1987) subject claims for physician office or home visits to the overall plan deductible. Almost all plans (98 percent in 1987) pay for physician office visits at a percentage of R&C charges. Eighty-four percent of plans (in 1987) requiring a deductible pay for office visits at 80 percent of R&C charges.

Physician visits to patients in hospitals are paid by almost all plans as a percentage of R&C charges. Sixty-seven percent of these plans subject inhospital physician visits to the overall plan deductible, and most (80 percent) pay for such visits at 80 percent of R&C charges.

The typical plan feature is for physician services to be subject to the overall plan deductible and then to be reimbursed at 80 percent of R&C charges.

6. X-ray and laboratory tests. Employer plans generally cover diagnostic X-rays and laboratory tests provided in a doctor's office, in an independent laboratory, or in a hospital outpatient department. Diagnostic X-ray and laboratory work was fully covered for two-fifths of public sector participants. Another two-fifths subject the diagnostic and laboratory tests to overall plan limits (such as through a deductible or coinsurance percentage).

Almost all of the Hay/Huggins plans (99 percent) cover such services as a percentage of R&C charges. A little over half (53 percent in 1987) require payment of a deductible (usually the overall plan deductible), after which most plans (74 percent) reimburse at 80 percent of R&C charges. Forty-four percent of plans that pay R&C charges require no deductible, and most (93 percent) of these plans pay at 100 percent of R&C charges.

The typical plan feature subjects x-ray and laboratory tests to the overall plan deductible and then reimburses at the overall plan coinsurance rate of 80 percent of R&C charges.

7. *Prescription Drug Coverage*

Prescription drug benefits pay the cost of covered outpatient drugs obtained with a prescription. (Drugs received in the inpatient hospital setting are paid for as a hospital benefit.) Major medical programs remain the most prevalent form of prescription drug coverage. Eighty-five percent of public plan participants were in plans that subjected prescription drugs to either a separate internal plan limit (33 percent) or to the overall plan limit (52 percent).

Eighty percent of the plans in the Hay/Huggins survey provide prescription drug coverage subject to the overall plan deductible, with the plan paying 80 percent of the bill.

The typical plan feature subjects prescription drugs to enrollee payment of the overall plan deductible and then pays at the overall coinsurance rate of 80 percent.

8. *Mental Health Care*

Plans usually apply special limits to inpatient and outpatient mental health care to limit coverage to short-term, non-custodial care.

a. Inpatient care. Fifty-four percent of the Hay/Huggins plans reimburse for room and board related to psychiatric care at less than 100 percent of R&C. The remaining 46 percent reimburse at 100 percent of R&C charges, with half of these using the same maximum as other confinements and the other half using a separate maximum. Most plans set a 30-day limit for inpatient psychiatric treatment.

The BLS survey of medium and large firms shows that, of the participants in plans with mental health benefits, 61 percent had more restrictive hospital coverage for mental illnesses than for other ailments in 1986, up from 54 percent in 1985 and 41 percent in 1981. These plans commonly reduced the duration of the hospital stay (often 30 days) and sometimes imposed a separate maximum on covered hospital expenses (such as a lifetime maximum of $50,000).

The BLS survey of State and local governments shows that 80 percent of participants in plans with mental health benefits had more restrictive hospital coverage for mental illness than for other ailments. The most common special limits were fewer days of hospitalization covered in full (often 30 days, compared to 365 days for other illnesses); and a separate, relatively low, ceiling on covered hospital expenses (such as a lifetime maximum of $50,000).

The typical plan feature pays 80 percent of the average semiprivate room charge with a maximum of 30 days per year.

b. Outpatient care. The BLS survey indicates that outpatient mental health coverage is more restrictive than inpatient care. Outpatient mental health care was usually covered in the major medical portion of a plan where: (1) ceilings were often placed on the amounts payable, and (2) the coinsurance rate was often 50 percent, compared to 80 percent for other illnesses. Also, limits on annual out-of-pocket major medical expenses usually did not apply to outpatient mental health care.

Most (about 98 percent) of the firms responding to the Hay/Huggins survey provide some level of outpatient mental health coverage. Most (85 percent) of these require payment of the overall plan deductible, after which the majority of plans (68 percent) pay 50 percent or less of the R&C charge.

Health care plans use a variety of other limits on outpatient mental health care. These include a limit on the number of visits (typically 50 visits) or a dollar amount that the plan will pay (typically $750 to $1,000).

The typical plan feature for outpatient mental health care combines the 50 percent coinsurance rate with an annual $1,000 limit.

9. *Dental Benefits*

Seventy-one percent of the private sector participants and 62 percent of the State and local sector participants in the BLS surveys received coverage for dental expenses. Nearly all dental plans covered a wide range of services including routine examinations, x-rays, and restorative services such as fillings, periodontal care, and inlays. Plans covering orthodontic expenses, at least for dependent children, covered 75 percent of private sector employees with dental benefits in 1986, and 68 percent of State and local government employees in 1987. Dental payments were most commonly based on a percentage of the R&C charge. The percentage covered generally depended on the type of procedure performed.

According to the BLS surveys, dental plans typically required the participants to pay a specified deductible before the plan paid any benefits (most commonly $25 to $50 each year). Eighty-eight percent of private sector participants and 79 percent of public employees were limited by a yearly maximum on dental benefits (usually $1,000).

Eighty-nine percent of the firms participating in the Hay/Huggins survey provide dental coverage covering dependents as well as employees. In most cases dental coverage is provided under a separate plan. Eighty-eight percent base payment on a percentage of the R&C charge, with the percentage paid varying by type of expense.

The typical plan feature pays a percentage of R&C charges that varies by type of procedure performed. Less costly services (such as x-rays and fillings) are reimbursed at 80 to 100 percent. More costly services (such as orthodontia) are reimbursed at 50 percent. There is a separate $50 deductible and a maximum yearly payment of $1,000.

See chapter 5 on *Comparability of FEHBP with Nonfederal Practice* for a table presenting the typical features of private sector health plans.

APPENDIX G. ADMINISTRATION: MONITORING HEALTH INSURANCE PROGRAMS

To effectively administer large health insurance programs, many private sector employers have found it beneficial to develop data systems which allow careful monitoring of health care expenditures and related expenses. In the case of FEHBP, the development of these types of data systems would require considerable resources. Especially during the implementation stage, reforming the current system would likely increase administrative costs and add to the administrative burden of all involved in FEHBP. The experience of such private-sector health care programs, however, appears to demonstrate that spending money on monitoring activities is worthwhile. Furthermore, because of its immense size, there is strong reason to believe that various monitoring activities would prove especially beneficial in FEHBP.

If it were decided that aggressive monitoring of FEHBP was desirable, it would probably be prudent to endow FEHBP's administrating agency with considerable flexibility, because it can be anticipated that the Nation's health care delivery system will continue to evolve rapidly; evolution carries with it the potential to render monitoring functions obsolete before they are fully implemented.

It should be recognized that building suitable data bases to effectively monitor FEHBP would also be time consuming--taking, perhaps, several years. One reason is that it would likely prove impractical to rely on much of the data already captured.

The data needed to monitor FEHBP, in either its present form or in a substantially modified program, falls largely into three categories: demographics, benefits, and information related to administration.

The initial building block in a data system is the identification of the eligible participants in the program: active employees and their dependents; and retired employees and their dependents.

For active employees, data should include social security number, date of birth, agency (by location), gender, salary, zip code of residence, and benefit option. Retiree data should include these same types of information plus status under Medicare. Dependent data should be a subset of both active employee and retiree information but include status and benefit coverage from other sources (i.e., insurance provided through spouse's employment).

Benefits data is the largest and most complex category of the system. These data should be categorized by employees, retirees, and dependents with or without Medicare. Benefit charges and paid (or accrued) claims should identify plan (and option), line of coverage (e.g., hospitalization, surgical), amount of expense, provider of service, and diagnosis, service, and item by a uniform identification numbering system. (See below for an outline of benefit data categories.)

Administrative data should identify the number of claims processed, average processing time, processing error ratios, claims involving coordination of benefits (and amount of savings), and claims appeals. Carriers should supply OPM with cash flow and accounting analyses of premium income or transfers, benefits and administrative expenses.

While much of this information currently exists within the current FEHBP structure, it is not in forms which permit access or analysis. Data are independently gathered and/or analyzed by the carriers, with only summaries being filed with OPM. Uniform data definition and identification would need to be applied to the carriers' data bases and then transferred to OPM in a prescribed format.

SAMPLE BENEFIT DATA SET

[Categorized by Employee, Dependent, and Retiree
with or without Medicare]

I. By Line of Coverage
   A. Number of claims paid
   B. Amount charged
   C. Amount paid by employee in deductibles
   D. Amount paid by employee in coinsurance
   E. Amount paid for expenses not covered
   F. Amount paid by plan
   G. Amount paid by plan as basic benefit
   H. Amount paid by plan under major medical

II. By Amount of Expenses
   A. Participants failing to reach individual deductible
   B. Participants failing to reach family deductible
   C. Plan expenses to $5,000
      $ 5,000 to $ 10,000
      $ 10,001 to $ 50,000
      $ 50,001 to $100,000
      $100,001 and up
   D. Participants meeting catastrophic limit

III. By Provider of Services
   A. Hospitalization--by name, tax identification number, and zip code
      1. Inpatient services by diagnosis-related group (DRG)
         a. Number of admissions
         b. Average length of stay
         c. Total charges
            (1) Room and board
            (2) Miscellaneous charges
         d. Discounts (if any)
         e. Total paid
         f. Average charges per day

- 2. Outpatient services by DRG
    - a. Number of occasions
    - b. Total charges
    - c. Discounts (if any)
    - d. Total paid
    - e. Average charge per occasion

B. Physician/Surgical--by name, tax identification number, and zip code
- 1. Inpatient by Common Procedure Terminology (CPT) code
    - a. Number of procedures
    - b. Total charges
    - c. Discounts (if any)
    - d. Total paid
    - e. Average charge per procedure
- 2. Outpatient by CPT code
    - a. Number of procedures
    - b. Total charges
    - c. Discounts (if any)
    - d. Total paid
    - e. Average charge per procedure

C. Physician/Medical--by name, tax identification number, and zip code
- 1. Inpatient by California Relative Value Schedule (CRVS) code
    - a. Number of procedures
    - b. Total charges
    - c. Discounts (if any)
    - d. Total paid
    - e. Average charge per procedure
- 2. Outpatient by CRVS code
    - a. Number of procedures
    - b. Total charges
    - c. Discounts (if any)
    - d. Total paid
    - e. Average charge per procedure

D. Radiology--by laboratory or tax identification number, and zip code
- 1. Inpatient by CRVS code
    - a. Number of procedures
    - b. Total charges
    - c. Discounts (if any)
    - d. Total paid
    - e. Average charge per procedure

E. Pathology--by laboratory or tax identification number, and zip code
- 1. Inpatient by CRVS code
- 2. See D(1)(a) through (e)

F. Dental--by dentist, tax identification number, and zip code
  1. By uniform American Dental Association (ADA) code
    a. Number of procedures
    b. Total charges
    c. Discounts (if any)
    d. Total paid
    e. Average cost per procedure

G. Prescription Drugs--by pharmacy, tax identification number, and zip code
  1. By drug identification number
    a. Number of prescription
      (1) Brand name
      (2) Brand name with generic equivalent
      (3) Generic
    b. Total charges
    c. Discounts (if any)
    d. Total paid
    e. Average cost per prescription

APPENDIX H. CHARACTERISTICS OF FEDERAL WORKERS BY THEIR FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM ENROLLMENT STATUS

The following figures present data on Federal workers (excluding postal) according to their enrollment status in FEHBP in 1988. The data describe workers according to their age, sex, marital status, and enrollment status in FEHBP. Average premiums are shown for workers enrolled in FEHBP in 1988 by their age and Federal salary. The figures are based on a CRS analysis of data provided by OPM.

A. FEHBP Enrollment Status by Age and Marital Status

Figure 1 shows FEHBP enrollment status in 1988 for active workers (excluding postal), by their age and marital status. Enrollment status is shown according to whether workers are enrolled in FEHBP Self Only or Family coverage, or whether they have waived coverage, or are ineligible for coverage.

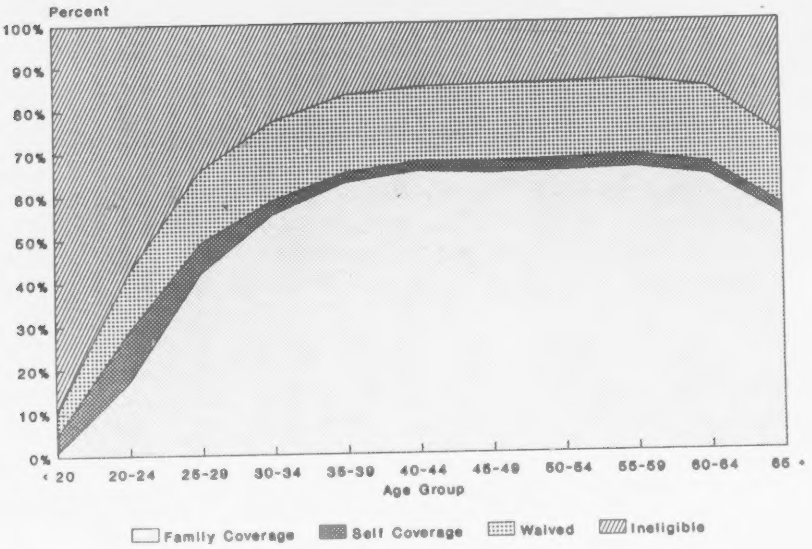
The figure shows that the majority of Federal workers are enrolled in FEHBP. About three out of five married workers and four out of five single workers are enrolled. A small portion (less than 5 percent) of married workers are enrolled in Self Only coverage under FEHBP. A somewhat greater share of single workers, nearly 10 percent between the ages of 25 and 49, are enrolled in Family coverage. Many of these single workers with Family coverage may be single parents with children.

A sizeable proportion of workers eligible for FEHBP coverage waived coverage in 1988. Among Federal workers, married workers are much more likely to waive coverage than their single counterparts; about 20 percent of married workers waived FEHBP coverage, compared to only about 5 percent of single workers. Presumably, married workers who waive FEHBP coverage are receiving health insurance coverage through the spouse's employment.

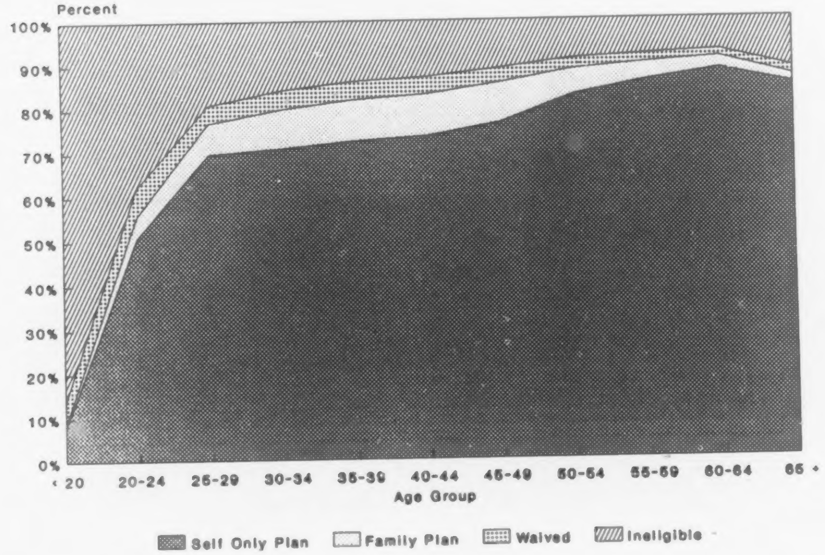
Married workers appear only slightly more likely to be excluded from FEHBP than single workers. Presumably, married workers comprise a greater share of workers who are either temporary or part-time employees.

FIGURE 1. FEHBP Enrollment Status of Active Workers, by Age and Marital Status, 1988
(excluding postal workers)

Married Workers



Single Workers



B. Age Distribution of Active Workers by FEHBP Enrollment Status

Younger workers are less likely than middle-aged and older workers to be enrolled in FEHBP. A large proportion of younger workers are ineligible for FEHBP coverage, presumably due to the preponderance of such workers being temporary or part-time employees. As figure 2 shows, active workers who waived FEHBP coverage are about the same age as workers enrolled in coverage. Persons ineligible for coverage generally tend to be much younger than enrollees. Data from other studies indicate that younger workers, lacking firmly established ties to the labor force, are overrepresented among persons without health insurance in the United States.[162]

C. FEHBP Enrollment Status by Age and Sex

Figure 3 shows that male Federal workers are more likely than female workers to be enrolled in FEHBP. The differences, however, are not due to differences in the proportion of each group who are ineligible for coverage--the proportion of each group ineligible is about the same between men and women. Rather, the difference appears to be due to the greater share of female workers who waived FEHBP coverage. Presumably, the majority of these women are married and receiving health insurance coverage through the husband's employment.

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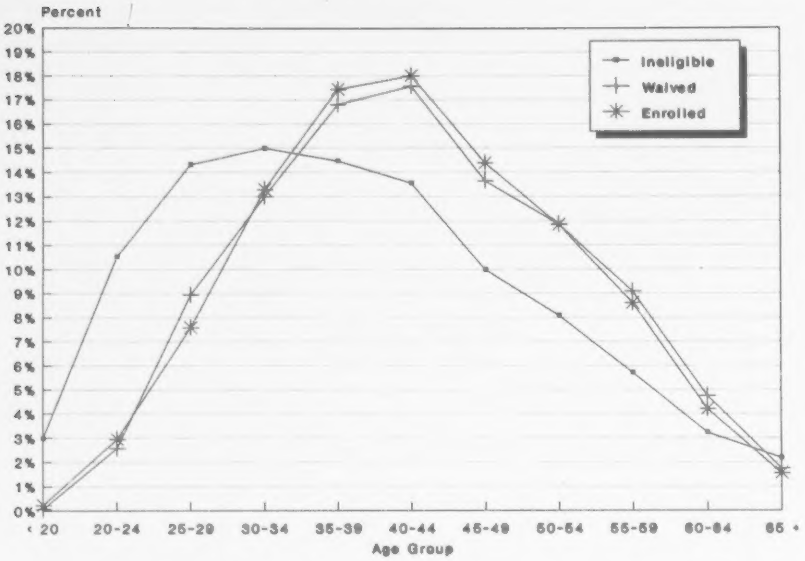
[162] U.S. Library of Congress. Congressional Research Service. Committee print prepared for Congress. *Costs and Effects of Extending Health Insurance Coverage*. Oct. 1988.

FIGURE 2. Age Distribution of Active Workers, by FEHBP Enrollment Status, 1988 (excluding postal workers)

Percent Distribution



Cumulative Percent Distribution

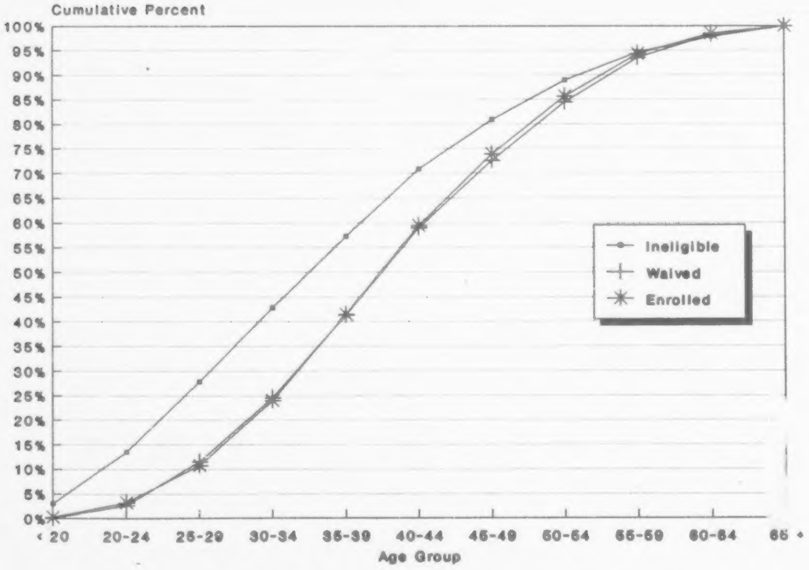
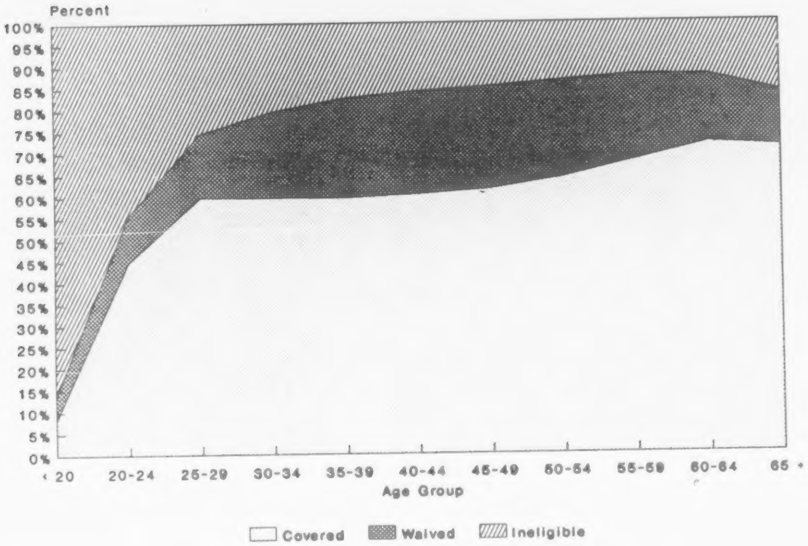
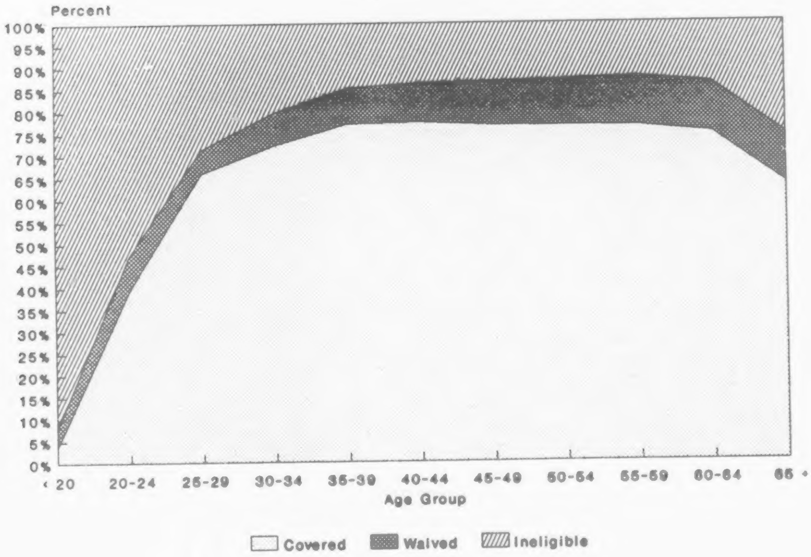


FIGURE 3. FEHBP Enrollment Status of Active Workers, by Age and Sex, 1988 (excluding postal workers)

Female Workers



Male Workers



D. FEHBP Premiums

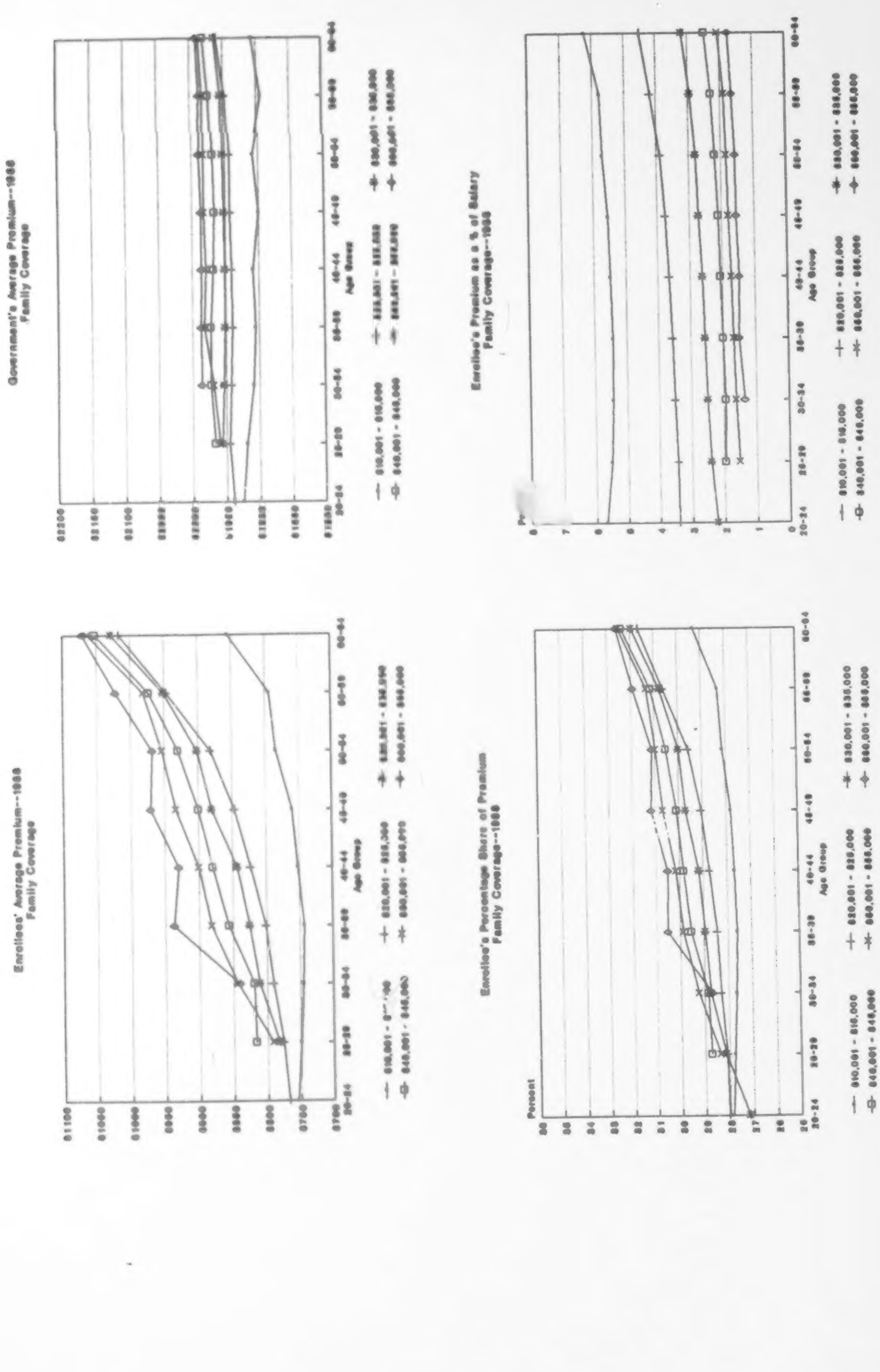
Figures 4 and 5 show average FEHBP premiums by enrollees' age and income, for workers in Self Only and Family coverage, respectively. The four panels of each chart show enrollees' average premium, the Government's average premium, average percentage share of the total premium paid by enrollees, and enrollees' average premium share as a percent of the enrollees' Federal earnings.

The figures show, for example, that older workers generally tend to select more costly plans than younger workers. For example, the average premium of a worker between the ages of 25 and 29, earning between $20,000 and $25,000 during the year, enrolled in Family coverage, was $776, compared to $1,017 for a worker age 60 to 64. The Government's average premium for the $20,000 to $25,000 worker was roughly the same, regardless of the worker's age--about $1,950 per year. This is because of the relatively fixed Government contribution amount based on the Big Six formula. While older workers are more likely than younger workers to be enrolled in higher-cost plans, the older worker, rather than the Government, bears most of the higher cost of the premiums for the higher-cost plans in which they are enrolled. The panel in the bottom left corner shows, for example, that the average worker's share of the total premium is about 28 percent for the age 25 to 29 worker noted above, but nearly 32 percent for the worker age 60 to 64.

Workers with higher incomes, on average, tend to enroll in more costly FEHBP plans than workers with lower incomes. The differences in FEHBP premiums paid are greatest among middle-aged workers. The difference in the average premium paid by a 35 to 39 year old worker earning $60,000 to $65,000 and similarly aged workers earning $20,000 to $25,000 is about $150; the difference in the Government share is about $50. As a result of the plans they choose, higher-income enrollees are assuming a greater share of the total cost of the higher-cost coverage they seek, although the premium dollars the Government pays tend also to be higher for higher-income workers.

In spite of the tendency of higher-paid workers to seek out more expensive FEHBP plans, the higher premiums paid by these workers represent a smaller percentage share of their salaries than do the premiums paid by lower-income workers, who are more likely to be enrolled in lower-cost FEHBP plans

FIGURE 4. Premiums of Active Workers Enrolled in FEHBP Self Only Coverage, 1988 (excluding postal workers)



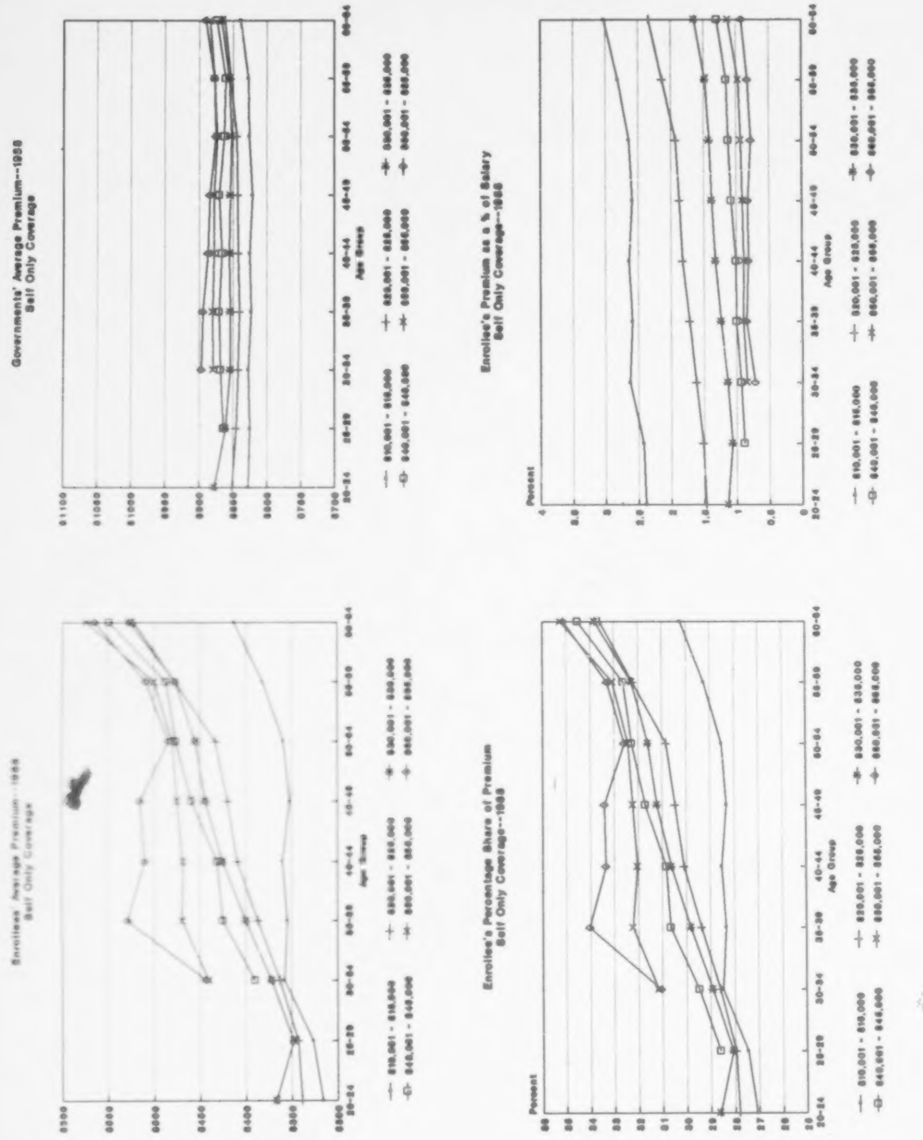
Enrollees' Average Premium--1988
Family Coverage

Government's Average Premium--1988
Family Coverage

Enrollee's Percentage Share of Premium
Family Coverage--1988

Enrollee's Premium as a % of Salary
Family Coverage--1988

FIGURE 5. Premiums of Active Workers Enrolled in FEHBP Family Coverage, 1988 (excluding postal workers)



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